AWARD/CONTRACT

1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 700) — RATING: DO-C9

2. CONTRACT (Proc. Inst. Ident.) NO.: HT9402-12-C-0001

3. EFFECTIVE DATE: See Block 20C

4. REQUISITION/PURCHASE REQUEST/PROJECT NO.: 12-OPS-0035

5. ISSUED BY — CODE HT9402

DEPARTMENT OF DEFENSE
TRICARE MANAGEMENT ACTIVITY COD-A
16401 E CENTRETECH PARKWAY
AURORA CO 80011-9066

6. ADMINISTERED BY (If other than Item 5) — CODE HT9402

DEPARTMENT OF DEFENSE
TRICARE MANAGEMENT ACTIVITY COD-A
16401 E CENTRETECH PARKWAY
AURORA CO 80011-9066

7. NAME AND ADDRESS OF CONTRACTOR (No., Street, City, Country, State and ZIP Code)

UNITEDHEALTH MILITARY VETERANS SERVICES LLC
9701 DATA PARK DRIVE
MINNETONKA MN 55343-9664

CODE 53JY0 — FACILITY CODE

8. DELIVERY: ☐ FOB ORIGIN ☒ OTHER (See below)

9. DISCOUNT FOR PROMPT PAYMENT: Net 30

10. SUBMIT INVOICES (4 copies unless otherwise specified) TO THE ADDRESS SHOWN IN — ITEM

11. SHIP TO/MARK FOR — CODE HT9402

DEPARTMENT OF DEFENSE
TRICARE MANAGEMENT ACTIVITY COD-A
16401 E CENTRETECH PARKWAY
AURORA CO 80011-9066

12. PAYMENT WILL BE MADE BY — CODE HT9402

DEPARTMENT OF DEFENSE
TRICARE MANAGEMENT ACTIVITY CRM
16401 CENTRETECH PARKWAY
AURORA CO 80011-9066

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION:
☐ 10 U.S.C. 2304 (c) (   ) ☐ 41 U.S.C. 253 (c) (   )

14. ACCOUNTING AND APPROPRIATION DATA: See Schedule

15A. ITEM NO	15B. SUPPLIES/SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
	Continued				

15G. TOTAL AMOUNT OF CONTRACT: $10,000,000.00

16. TABLE OF CONTENTS

CONTRACTING OFFICER WILL COMPLETE ITEM 17 (SEALED-BID OR NEGOTIATED PROCUREMENT) OR 18 (SEALED-BID PROCUREMENT) AS APPLICABLE

17. ☒ CONTRACTOR'S NEGOTIATED AGREEMENT (*Contractor is required to sign this document and return* 1 *copies to issuing office.*) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (*Attachments are listed herein.*)

18. ☐ SEALED-BID AWARD (*Contractor is not required to sign this document.*) Your bid on Solicitation Number ________ including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your bid, and (b) this award/contract. No further contractual document is necessary. (Block 18 should be checked only when awarding a sealed-bid contract.)

19A. NAME AND TITLE OF SIGNER (Type or print): Lori C. McDougal CEO UnitedHealth Military Vet...

20A. NAME OF CONTRACTING OFFICER: Andrew C. Obermeyer, andrewobermeyer@tma.osd.mil

19B. NAME OF CONTRACTOR — BY Lori C. McDougal (Signature of person authorized to sign)

19C. DATE SIGNED: 3/19/2012

20B. UNITED STATES OF AMERICA — BY Andrew C Obermeyer (Signature of the Contracting Officer)

20C. DATE SIGNED: 3/20/2012

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	DUNS Number: 826295136 Base Period CLIN 0001				
0001	Transition In Obligated Amount: $10,000,000.00 Accounting Info: 9712120130.1889.102000 (FY12) Funded: $10,000,000.00 OPTION PERIOD 1				10,000,000.00
1001	Underwritten Health Care Cost for Contractor Network Prime Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				1,310,105,915.00
100101	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100102	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1002	Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				1,976,137,426.00
100201	FY13 Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Qty:0 and Amt: $0.00) (Option Line Item)				
100202	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1003	Fixed Fee for CLIN 1001 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
100301	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100302	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1004	Fixed Fee for CLIN 1002 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
100401	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100402	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost) Continued ...				9,876,906.00

CONTINUATION SHEET	REFERENCE NO. OF DOCUMENT BEING CONTINUED HT9402-12-C-0001	PAGE 4 OF 101

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Informational SLINs to identify multiple accounting classifications: (Option Line Item)				
100501	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100502	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1006	Fixed Fee for CLIN 1005 (Cost plus fixed fee)	12	MO	(b) (4)	
	Informational SLINs to identify multiple accounting classifications: (Option Line Item)				
100601	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100602	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1007	Electronic Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	16111000	EA	(b) (4)	
100701	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100702	FY14 Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Qty:0 and Amt: $0.00) (Option Line Item)				
1008	Paper Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	2101000	EA	(b) (4)	
100801	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
100802	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1009	Per Member Per Month (Fixed Price) (Option Line Item)				
1009AA	Per Member Per Month (Estimated Quantity) First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17296003	EA	(b) (4)	
1009AB	Per Member Per Month (Estimated Quantity) Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17296003	EA	(b) (4)	
1010	TRICARE Service Centers (Firm fixed price) Informational SLINs to identify multiple accounting classifications: (Option Line Item) Continued ...	12	MO	(b) (4)	

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
101001	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
101002	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
1011	Award Fee Pool (Option Line Item) (Not Separately Priced)				
1011AA	Award Fee Pool First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
1011AB	Award Fee Pool Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
1012	Performance Incentive Pool for H.2. and H.3. Informational SLINs to identify multiple accounting classifications: (Option Line Item)				(b) (4)
101201	FY13 (Qty:0 and Amt: $0.00) (Option Line Item)				
101202	FY14 (Qty:0 and Amt: $0.00) (Option Line Item) Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
1013	Reports, Contract Data Requirements List (DD Form 1423) (Option Line Item) (Not Separately Priced)				
1014	Clinical Support Agreement Program (Option Line Item)				
1015	Service Assist Teams (Time and Material) Labor Rates - SECT J, EXHIBIT A (Option Line Item)				
	OPTION PERIOD 2				
2001	Underwritten Health Care Cost for Contractor Network Prime Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				1,429,359,421.00
200101	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200102	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2002	Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees (Cost plus fixed fee) (Estimated Cost) Continued ...				2,087,304,459.00

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NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Informational SLINs to identify multiple accounting classifications: (Option Line Item)				
200201	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200202	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2003	Fixed Fee for CLIN 2001 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
200301	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200302	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2004	Fixed Fee for CLIN 2002 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
200401	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				

Continued ...

CONTINUATION SHEET

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NAME OF OFFEROR OR CONTRACTOR: UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
200402	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				11,237,166.00
200501	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200502	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2006	Fixed Fee for CLIN 2005 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
200601	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200602	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2007	Electronic Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item) Continued ...	17501000	EA	(b) (4)	

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
200701	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200702	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2008	Paper Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	1972000	EA	(b) (4)	
200801	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
200802	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2009	Per Member Per Month (Fixed Price) (Option Line Item)				
2009AA	Per Member Per Month (Estimated Quantity) First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17203706	EA	(b) (4)	
2009AB	Per Member Per Month (Estimated Quantity) Second Biannual Period (Option Line Item) Accounting Info: Continued ...	17203706	EA	(b) (4)	

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Funded: $0.00				
2010	TRICARE Service Centers (Firm fixed price) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
201001	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
201002	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2011	Award Fee Pool (Option Line Item) (Not Separately Priced)				
2011AA	Award Fee Pool First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
2011AB	Award Fee Pool Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
2012	Performance Incentive Pool for H.2. and H.3. Informational SLINs to identify multiple accounting classifications: (Option Line Item)				(b) (4)

Continued ...

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
201201	FY14 (Qty:0 and Amt: $0.00) (Option Line Item)				
201202	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
2013	Reports, Contract Data Requirements List (DD Form 1423) (Option Line Item) (Not Separately Priced)				
2014	Clinical Support Agreement Program (Option Line Item)				
2015	Service Assist Teams (Time and Material) Labor Rates - SECT J, EXHIBIT A (Option Line Item)				
	OPTION PERIOD 3				
3001	Underwritten Health Care Cost for Contractor Network Prime Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				1,568,754,259.00
300101	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300102	FY16 Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Qty:0 and Amt: $0.00) (Option Line Item)				
3002	Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				2,223,870,431.00
300201	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300202	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3003	Fixed Fee for CLIN 3001 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
300301	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300302	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3004	Fixed Fee for CLIN 3002 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: Continued ...	12	MO	(b) (4)	

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Option Line Item)				
300401	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300402	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				11,574,281.00
300501	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300502	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3006	Fixed Fee for CLIN 3005 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
300601	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300602	FY16 (Qty:0 and Amt: $0.00) Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Option Line Item)				
3007	Electronic Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	18890000	EA	(b) (4)	
300701	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300702	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3008	Paper Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	1854000	EA	(b) (4)	
300801	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
300802	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3009	Per Member Per Month (Fixed Price) (Option Line Item)				
3009AA	Per Member Per Month (Estimated Quantity) First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00 Continued ...	17190332	EA	(b) (4)	

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NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3009AB	Per Member Per Month (Estimated Quantity) Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17190332	EA	(b) (4)	
3010	TRICARE Service Centers (Firm fixed price) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
301001	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
301002	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3011	Award Fee Pool (Option Line Item) (Not Separately Priced)				
3011AA	Award Fee Pool First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
3011AB	Award Fee Pool Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00 Continued ...				(b) (4)

NAME OF OFFEROR OR CONTRACTOR

UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3012	Performance Incentive Pool for H.2. and H.3. Informational SLINs to identify multiple accounting classifications: (Option Line Item)				(b) (4)
301201	FY15 (Qty:0 and Amt: $0.00) (Option Line Item)				
301202	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
3013	Reports, Contract Data Requirements List (DD Form 1423) (Option Line Item) (Not Separately Priced)				
3014	Clinical Support Agreement Program (Option Line Item)				
3015	Service Assist Teams (Time and Material) Labor Rates - SECT J, EXHIBIT A (Option Line Item)				
	OPTION PERIOD 4				
4001	Underwritten Health Care Cost for Contractor Network Prime Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				1,722,478,559.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
400101	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400102	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4002	Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				2,375,235,626.00
400201	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400202	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4003	Fixed Fee for CLIN 4001 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
400301	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400302	FY17 (Qty:0 and Amt: $0.00) Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Option Line Item)				
4004	Fixed Fee for CLIN 4002 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
400401	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400402	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				11,921,510.00
400501	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400502	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4006	Fixed Fee for CLIN 4005 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	

Continued ...

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
400601	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400602	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4007	Electronic Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	20280000	EA	(b) (4)	
400701	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400702	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4008	Paper Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	1747000	EA	(b) (4)	
400801	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
400802	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4009	Per Member Per Month (Fixed Price) (Option Line Item)				

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NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
4009AA	Per Member Per Month (Estimated Quantity) First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17158211	EA		(b) (4)
4009AB	Per Member Per Month (Estimated Quantity) Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17158211	EA		(b) (4)
4010	TRICARE Service Centers (Firm fixed price) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
401001	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
401002	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4011	Award Fee Pool (Option Line Item) (Not Separately Priced)				
4011AA	Award Fee Pool First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00 Continued ...				(b) (4)

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
4011AB	Award Fee Pool Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
4012	Performance Incentive Pool for H.2. and H.3. Informational SLINs to identify multiple accounting classifications: (Option Line Item)				(b) (4)
401201	FY16 (Qty:0 and Amt: $0.00) (Option Line Item)				
401202	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
4013	Reports, Contract Data Requirements List (DD Form 1423) (Option Line Item) (Not Separately Priced)				
4014	Clinical Support Agreement Program (Option Line Item)				
4015	Service Assist Teams (Time and Material) Labor Rates - SECT J, EXHIBIT A (Option Line Item)				
	OPTION PERIOD 5				
5001	Underwritten Health Care Cost for Contractor Network Prime Enrollees Continued ...				1,887,717,560.00

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				
500101	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500102	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5002	Underwritten Health Care Cost for Non-Prime Underwritten Beneficiaries and MTF Enrollees (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				2,537,370,312.00
500201	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500202	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5003	Fixed Fee for CLIN 5001 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	

Continued ...

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
500301	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500302	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5004	Fixed Fee for CLIN 5002 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
500401	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500402	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5005	Disease Management Cost (Cost plus fixed fee) (Estimated Cost) Informational SLINs to identify multiple accounting classifications: (Option Line Item)				12,279,155.00
500501	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500502	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
	Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
5006	Fixed Fee for CLIN 5005 (Cost plus fixed fee) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
500601	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500602	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5007	Electronic Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	21670000	EA		(b) (4)
500701	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500702	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5008	Paper Claims Processing (Fixed Price) (Estimated Quantity) (Option Line Item)	1649000	EA		(b) (4)
500801	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
500802	FY18 (Qty:0 and Amt: $0.00) Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Option Line Item)				
5009	Per Member Per Month (Fixed Price) (Option Line Item)				
5009AA	Per Member Per Month (Estimated Quantity) First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17139893	EA	(b) (4)	
5009AB	Per Member Per Month (Estimated Quantity) Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00	17139893	EA	(b) (4)	
5010	TRICARE Service Centers (Firm fixed price) Informational SLINs to identify multiple accounting classifications: (Option Line Item)	12	MO	(b) (4)	
501001	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
501002	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5011	Award Fee Pool (Option Line Item) (Not Separately Priced)				

Continued ...

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
5011AA	Award Fee Pool First Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
5011AB	Award Fee Pool Second Biannual Period (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
5012	Performance Incentive Pool for H.2. and H.3. Informational SLINs to identify multiple accounting classifications: (Option Line Item)				(b) (4)
501201	FY17 (Qty:0 and Amt: $0.00) (Option Line Item)				
501202	FY18 (Qty:0 and Amt: $0.00) (Option Line Item)				
5013	Reports, Contract Data Requirements List (DD Form 1423) (Option Line Item) (Not Separately Priced)				
5014	Clinical Support Agreement Program (Option Line Item)				
5015	Service Assist Teams (Time and Material) Labor Rates - SECT J, EXHIBIT A Continued ...				

NAME OF OFFEROR OR CONTRACTOR
UNITEDHEALTH MILITARY VETERANS SERVICES LLC

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Option Line Item)				
9001	Transition Out (Cost Plus Fixed Fee) Option Periods 1-5 (As needed) (Option Line Item) Accounting Info: Funded: $0.00				(b) (4)
9002	Fixed Fee for CLIN 9001 (Cost Plus Fixed Fee) (Option Line Item) Accounting Info: Funded: $0.00				(b)(4)

1.0 GENERAL. Section C includes two categories of outcome based statements: Objectives and Technical Requirements. The "Objectives" represent the outcomes for this contract and are supported by technical requirements. These requirements represent specific tasks, outcomes, and/or standards that, at a minimum, shall be achieved. The purpose of this contract is to provide Managed Care Support (MCS) to the Department of Defense (DoD) TRICARE program. The MCS Contractor shall assist the Military Health System in operating an integrated health care delivery system combining resources of the military's direct medical care system and the Contractor's managed care support to provide health, medical and administrative support services to eligible beneficiaries.

2.0 DOCUMENTS. The following documents, including the changes identified below, are hereby incorporated by reference and made a part of the contract.

These documents form an integral part of this contract. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text.

Title 10, United States Code, Chapter 55
32 Code of Federal Regulations, Part 199

TRICARE Policy Manual (TPM) 6010.57-M dated February 1, 2008 with change 56.
TRICARE Reimbursement Manual (TRM) 6010.58-M dated February 1, 2008 with change 57.
TRICARE Systems Manual (TSM) 7950.2-M dated February 1, 2008 with change 29.
TRICARE Operations Manual (TOM) 6010.56-M dated February 1, 2008 with change 59.

The TRICARE Manuals provide instruction, guidance and responsibilities in addition to the requirements set forth in the incorporated federal statutes and regulations and may not be interpreted in contradiction thereto. Among the Manuals the TRICARE Policy Manual takes precedence over the other three TRICARE Manuals. The TRICARE Reimbursement Manual takes precedence over the TRICARE Systems Manual and the TRICARE Operations Manual. The TRICARE Systems Manual takes precedence over the TRICARE Operations Manual.

3.0 DEFINITIONS. Definitions are included in the TRICARE Operations Manual, Appendix B.

4.0 GOVERNMENT FURNISHED PROPERTY. At certain Military Treatment Facilities (MTFs), facilities and Government Furnished Equipment may be provided for the TRICARE Service Center (TSC). FAR 52.245-1, Government Furnished Property (GFP) describes the Contractor's management responsibilities and use of GFP. The GFP is provided in an "as-is" condition and subject to terms discussed in the referenced FAR clause. The GFP inventory will be identified in the MTF/Regional Director MOU prepared by the Contractor during the transition phase of the contract.

5.0 OBJECTIVES. The following are the objectives of this contract.

Objective 1 – In partnership with the Military Health System (MHS), optimize the delivery of health care services in the direct care system (see the definition of Military Treatment Facility Optimization in the TRICARE Operations Manual, Appendix B) for all MHS beneficiaries (active duty personnel, MTF enrollees, civilian network enrollees, and non-enrollees).

Objective 2 - Beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services. Beneficiaries must be completely satisfied with each and every service provided by the Contractor during each and every contact.

Objective 3 - Attain "best value health care" (See TRICARE Operations Manual, Appendix B) services in support of the MHS mission utilizing commercial practices when practical.

Objective 4 - Fully operational services and systems at the start of health care delivery and minimal disruption to beneficiaries and MTFs.

Objective 5 – Full and real time access to Contractor maintained data to support the DoD's financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities.

6.0 REQUIREMENTS. The Contractor must fulfill the following requirements, which are supplemented via the documents incorporated at paragraph 2.0.

PROVIDER NETWORKS

N.1. The Contractor shall provide a managed, stable, high-quality network, or networks, of individual and institutional health care providers which supplements the clinical services provided to MHS beneficiaries in MTFs and promotes access, quality, beneficiary satisfaction, and "best value health care" for the Government. (See the TOM, Appendix B for the definition of "best value health care.") The network, or networks, shall be sufficient in number, mix, and geographic distribution of fully qualified providers to provide the full scope of benefits for which all Prime enrollees are eligible under this contract, as described in 32 CFR 199.4, 199.5, and 199.17. The Contractor shall provide copies of network provider agreements when requested by the Contracting Officer or Contracting Officer's Representative (COR).

N.2. The Contractor shall establish provider networks for the delivery of Prime and Extra services to ensure that all access standards (see 32 CFR 199.17(p)(5)) are met at the start of health care delivery and continuously maintained in all Prime Service Areas (PSAs) in the region. PSAs (i.e., areas in which the Contractor offers enrollment in TRICARE Prime in compliance with the travel time access standard) shall encompass the entire area of all the zip codes lying within or intersected by the 40 mile radius around MTFs (both hospitals and clinics) and Base Realignment and Closure (BRAC) sites. For BRAC sites, the 40 mile radius shall be determined based on the former location of the MTF, if known. If the former MTF location is not known, the 40 mile radius shall be determined from the geographic center of the BRAC site zip code as of the date of contract award. The Contractor must provide PSAs at all MTF locations as listed in Attachment J-1, Government Required MTF Prime Service Areas, and at all sites listed in Attachment J-2, Government Required BRAC Site Prime Service Areas. The Contractor may propose additional or expanded PSAs. If necessary, to ensure provision of specialty medical services, the Contractor may establish specialty networks outside the PSA. Using the ESRI ArcView 9.2 mapping software program, or a mapping program producing results that can be electronically exported to the ESRI ArcView 9.2 mapping software for display, the Contractor shall identify a one-hour travel time contour around each MTF listed in Attachment 1. The MTF will have right of first refusal for provision of specialty care to TRICARE Prime enrollees who reside within the contour. All network providers must be Medicare participating providers unless they are not eligible to be participating providers under Medicare. The network must include providers in sufficient quantity and diversity to meet the access standards of 32 CFR 199.17(p)(5) for the MHS Medicare population residing in the Prime Service Area.

N.3. The Contractor's network and utilization management, and case management programs shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery and be maintained in all geographic areas covered by this contract and shall be maintained throughout the contract and all exercised options. When this contract and the accrediting body have differing standards for the same activity, the higher standard shall apply.

N.4. Network inadequacy is defined as any failure to provide health care services within the network within the access standards and one of the measures for network adequacy will be the percentage of claims submitted by network providers after excluding claims for emergency room, Point of Service, out-of-region, and Other Health Insurance. After assisting the beneficiary with accessing the needed care within access standards, the Contractor shall inform the Government in a monthly report of any instances of network inadequacy relative to the Prime and/or Extra service areas (see Section F). The Contractor will submit a corrective action plan for instances of network inadequacy that are significant (ex., the only specialist in a certain specialty leaves the network, a major hospital or system leaves the network) and/or any inadequacy that is likely to persist more than 30 days. The Contractor shall respond to any inquiries of the Government concerning any aspect of network inadequacy from a Contracting Officer, or a COR. The response shall be accomplished within two business days from receipt of a request.

N.4.1. The Contractor shall ensure that the following minimum percentages of numbers of claims for Prime enrollees region-wide are from network providers, (excluding claims for emergency room, Point of Service, out-of-region, and Other Health Insurance and TRICARE Prime Remote members). The percent for the number of claims from network providers will increase 1% each option period. For example, the West Option Period 1 standard of 72% shall be increased by one percentage point to 73% for Option Period 2.

Option Period 1	
West	72%

N.5. The Contractor shall adjust provider networks and services as necessary to compensate for changes in MTF capabilities and capacities, when and where they occur over the life of the contract, including those resulting from short-notice unanticipated facility expansion, MTF provider deployment, downsizing and/or closures. Changes in MTF capabilities and capacities may occur frequently over the life of the contract without prior notice. The Contractor shall ensure that all eligible beneficiaries who live in PSAs have the opportunity to enroll, add additional family members, or remain enrolled in the Prime program regardless of such changes. The Contractor shall ensure that MTF enrollees residing outside PSAs have the opportunity to add additional family members or remain enrolled in the Prime program regardless of such changes.

N.6. To coincide with the beginning of Option Period 1, the Government will automatically disenroll any enrolled beneficiary residing outside a T-3 PSA. The Contractor shall ensure the network has the capability and capacity to permit each beneficiary enrolled in Prime to a civilian Primary Care Manager (PCM) prior to the beginning of Option Period 1 and residing outside of PSAs under this contract to enroll to a PSA PCM at the beginning of Option Period 1, provided the beneficiary resides less than 100 miles from an available network primary care manager in the PSA, submits a new request for enrollment, and waives both primary and specialty care travel time standards. Beneficiaries enrolled in Prime to a civilian PCM prior to the beginning of Option Period 1 who reside outside of PSAs under this contract and are 100 miles or more from an available PCM in the PSA network shall not be granted a new enrollment. The Contractor shall refund the unused portion (based on a monthly proration) of either a quarterly or annual enrollment fee payment for any beneficiary who must be disenrolled because they reside outside a PSA at the start of Option Period 1. If a beneficiary pays on a monthly basis, no monthly payment(s) shall be received for these beneficiaries.

N.7. The Contractor will not be required to establish a network with the capability and capacity to grant new enrollments to beneficiaries who reside outside a PSA. The Contractor shall grant a request for a new enrollment to the network from a beneficiary residing outside a PSA provided there is sufficient unused network capability and capacity to accommodate the enrollment, the PSA network primary care manager to be assigned is located less than 100 miles from the beneficiary's residence, and the beneficiary waives both primary and specialty care travel time standards.

N.8. The Contractor shall ensure that the standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time for various categories of services contained in 32 CFR 199.17(p)(5) are met for beneficiaries residing in TRICARE PSAs. These standards shall be met in a manner which achieves beneficiary satisfaction with access to network providers and services as set forth in the contract. The Contractor shall define metrics, and collect data about them, that give insight to the degree to which the access standards are being met.

N.9. The Contractor shall have an active provider education program designed to enhance the provider's awareness of TRICARE requirements, to include emphasis on achieving the leading health care indicators of Healthy People program, and encourage participation in the program.

N.10. The Contractor shall inform network providers, through network provider agreements, that they agree to being reported to the Department of Veterans Affairs (VA) as a TRICARE network provider. The Contractor shall request non-institutional network providers to accept requests from VA to provide care to veterans. The agreement will give VA the right to directly contact the provider and request that he/she provide care to VA patients on a case by case basis. The Contractor shall require network providers (individual, home health care, free-standing laboratories, and free-standing radiology only) who accept VA patients to serve as a participating provider and accept assignment with the VA. If seen by the network provider, any documentation of the care rendered to the VA patient and reimbursement for the care is a matter between the referring VA Medical Center (VAMC) and the provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the patient at the time of the appointment. Those providers who express a willingness to receive VA queries as to availability shall be clearly identified with readily discernable markings on all public network provider listings. (Note: Nothing prevents the VA and the provider from establishing a direct contract relationship if the parties so desire. A direct contract relationship between a provider and the VA takes precedence over the requirements of this section.)

N.10.1. The Contractor shall inform network providers, through network provider agreements, that they agree to being reported to Civilian Health and Medical Program of the Department of Veteran's Administration (CHAMPVA) as a TRICARE network provider. The Contractor shall require network providers (individual, home health care, free-standing laboratories, and free-standing radiology only) who accept CHAMPVA patients to serve as a participating provider and accept assignment with the VA. The Contractor shall provide to the provider the CHAMPVA furnished claims processing instructions (Attachment J-4, CHAMPVA Fact Sheet 01-16 dated Aug 06) on how to submit CHAMPVA claims to the VA Health Administration Center P.O. Box 65024, Denver, CO 80206-9024 for payment. For any published network provider listing, the provider shall be clearly identified with readily discernable markings which accept CHAMPVA assignment on claims.

N.10.2. The Contractor shall request marketing and educational information on the VA and CHAMPVA through the VA Health Administration Center in sufficient quantities to provide the information to providers who agree to be listed as VA or CHAMPVA providers. [The Contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.] The Contractor may brief these materials to VA and CHAMPVA accepting providers.

N.11. The Contractor shall maintain an accurate, up-to-date list of network providers including their specialty, sub-specialty, gender, work address, work fax number, and work telephone number for each service area, and whether or not they are accepting new beneficiaries. The Contractor shall provide easy access to this list, to include making it available upon request, for all beneficiaries, providers, and Government representatives. For the purposes of this requirement, "up-to-date" means the information contained on all electronic lists shall be current within the last 30 calendar days.

REFERRAL MANAGEMENT

RM.1. In TRICARE PSAs that include an MTF, the MTF has the right of first refusal for all referrals. Medical care and ancillary capabilities for which this right is claimed by the MTF shall be specifically addressed in the MTF/MCSC Memorandum of Understanding (MOU). For referrals to the MTF for specialty care, travel time shall not exceed one hour under normal circumstances. Right of first refusal is defined as providing the MTF with an opportunity to review each referral from a civilian provider to determine if the MTF has the capability and capacity to provide the medical care and ancillary services previously identified in the MTF/MCSC MOU. All referrals shall be processed in accordance with TRICARE Operations Manual Chapter 8, Section 5.

RM.2. A minimum of ninety-six percent of referrals for Prime enrollees, who reside in TRICARE PSAs and Prime enrollees who reside outside TRICARE PSAs and have waived the travel-time access standards shall be referred to the MTF or a civilian network provider. This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual. All referrals, except the following, will be included to determine compliance with the standard: (1) referrals that are unknown to the Contractor before the visit (specifically ER visits, retroactively authorized referrals), (2) self referrals and referrals of beneficiaries who use other health insurance as first payer, (3) MTF directed referrals to non-network providers when network providers are available and 4) the eight mental health self-referrals. All other referrals are included in the standard without exception.

RM.2.1. The Contractor shall ensure that TRICARE Prime beneficiaries have no liability for amounts billed, except for the appropriate co-payment, for referred care, including ancillary services from a non-network provider as a result of a medical emergency or as a result of the TRICARE Prime beneficiary being referred to a non-network/non-participating provider by the Contractor. (For example, this requirement applies when a beneficiary is referred for surgery from a network surgeon in a network hospital, but the anesthesiologist is a non-network provider.) For these beneficiaries, amounts paid by the Contractor in excess of TRICARE allowable amounts (e.g., CHAMPUS Maximum Allowable Charge (CMACs), Diagnosis Related Groups (DRGs), Outpatient Prospective Payment System (OPPS), other prospective payment systems, or prevailing charges) to non-network/non-participating providers shall not be reported or used as underwritten health care costs.

RM.3. MTFs will refer their TRICARE Prime enrollees to a non-network civilian provider only when it is clearly in the best interest of the Government and the beneficiary, either clinically or financially. Such cases are expected to be rare. Federal health care systems (for example Veterans Administration and Indian Health Service) are excluded from this Government policy.

RM.4. The Contractor's referral management processes shall ensure an evaluation of the referred service is conducted to determine if the type of service is a TRICARE benefit and shall inform the beneficiary prior to the visit in the event the requested service is not a TRICARE benefit. This does not apply to referrals for active duty service members. This shall not be a preauthorization review. Rather, this process shall be a customer service/provider relations function providing an administrative coverage review. This service shall be accomplished for every referral received by the Contractor regardless of whether it was generated by an MTF provider, network provider or non-network provider.

RM.5. The Contractor shall meet with the Regional Director and each MTF in a collaborative and partnering manner to ensure balanced specialty workloads using the Contractor's referral protocols with the MTF as the first referral site. The Contractor shall provide each MTF with referral information concerning any MTF enrollee within 24 hours of a referral. The Contractor will not be required to track individual consultation reports. The referral information provided, and the methods of communicating the information, will be addressed in the MTF/MCSC MOU.

MEDICAL MANAGEMENT

MM.1. The Contractor shall ensure that care it provides, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5. The Contractor shall use its best practices in managing, reviewing and authorizing health care services, and shall comply with the provisions of 32 CFR 199.4, 32 CFR 199.5 and the TRICARE Policy Manual when reviewing and approving medical care and establishing medical management programs to carry out this activity to the extent authorized by law.

MM.2. The Contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract and shall follow all standards, rules, and procedures as defined in 32 CFR 199.15. The Contractor, using its authority as a PRO, shall apply its own utilization management practices to inpatient care received by MTF enrollees in a civilian setting consistent with MTF referral instructions. The Contractor shall fax a copy (or by other electronic means addressed in each MTF MOU) of these utilization management decisions to the MTF Commander the day the decision is made.

MM.3. The Contractor shall comply with the Clinical Quality Management requirements of the TRICARE Operations Manual, Chapter 7.

MM.4. The Contractor shall operate a medical management program for all MHS eligible beneficiaries receiving care in the civilian sector that achieves the objectives of this contract. The Contractor's medical management program must fully support the services available within the MTF.

MM.4.1. The Contractor shall operate case management programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which evidenced based clinical management programs exist. These programs shall be available to TRICARE eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 CFR 199 and active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. These programs shall exclude Medicare dual eligible beneficiaries. When care occurs outside an MTF, the Contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. The Contractor shall propose medical management programs and patient selection criteria for review and concurrence of the Contracting Officer prior to implementation and annually thereafter.

MM.4.1.2. The Contractor shall maintain open communication with the DoD dental Contractors in discussions to improve disease surveillance, disease management and appropriate patient education and research.

MM.4.2. The Contractor shall operate a Disease Management Program. Disease management conditions will be Asthma, Congestive Heart Failure (CHF), Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Cancer Screening, Depression and Anxiety Disorder. The Government will identify the population, and risk-stratify beneficiaries for inclusion in the Contractor's Disease Management Program. The Contractor shall make telephone contact and conduct a baseline assessment with at least 50% of the beneficiaries enrolled in the program for each disease condition at all risk levels within 12 months of identification by the Government. The Contractor shall submit a Disease Management Program Plan, required under Section F.5.1.7, which demonstrates implementation of the disease management intervention(s) that use the VA/DoD clinical practice guidelines, when available. The Contractor's Disease Management Programs shall meet national accreditation standards for disease management and chronic care management within 18 months of the start of healthcare delivery. The Contractor's plan shall include program information that will be provided to the Government, which when combined with other Government generated data will allow for effective evaluation of the Disease Management Program in accordance with the Government provided disease management outcome metrics. In order for the Government to be able to evaluate the Contractor's Disease Management Program, the Contractor shall include a Disease Management Program Plan for accounting and reporting on the cost and performance of all disease management programs, plus provide the specific guidelines and protocols they will utilize. The plan and cost estimate are subject to review and concurrence by the Contracting Officer prior to implementation and annually thereafter. The parties agree the fee as stated in the Disease Management CLINs will not change if the Government changes the diseases or stratification.

MM.5. In cooperation with the MTF, the Contractor shall, during normal business hours, in accordance with the MCSC/MTF MOU, coordinate the care and transfer of stabilized patients who require a transfer from one location to another. This function shall include coordination with the primary clinician at the losing and gaining sites, the patient's family, arranging medically appropriate patient transport, ensuring all necessary supplies are available during the transport and at the receiving location, arranging for and ensuring the presence of all necessary medical equipment during transport and at the receiving location, and identifying and ensuring the availability of necessary resources to accomplish the transfer. Transfers may occur as a result of medical, social, or financial reasons and include moves of non-institutionalized and institutionalized patients. Transportation will be coordinated using Government resources when appropriate and available.

ENROLLMENT

E.1. The Contractor shall perform all enrollments, re-enrollments, disenrollments, transfer enrollments, correct enrollment discrepancies, and assign or change the PCM in accordance with the provisions of the TRICARE Operations Manual, the TRICARE Policy Manual, and the TRICARE Systems Manual. The Contractor shall accomplish primary care manager by name assignment in accordance with the TRICARE Systems Manual. For beneficiaries returning from or transferring to OCONUS, the Contractor shall follow the requirements of the TRICARE Operations Manual.

E.2. Beneficiaries residing within the travel time access standard for primary care from the MTF and required to enroll in TRICARE Prime or choosing to do so shall be enrolled to the MTF, according to the MTF Commander's enrollment priorities and guidelines as stated in the Memorandum of Understanding, on a first come, first served basis, until the enrollment capacity established by the MTF Commander is reached. The Contractor shall ensure that MTF capacity, as determined by the MTF Commander, is reached before beneficiaries may be enrolled to the Contractor's network.

E.3. A beneficiary enrolled in Prime to a civilian PCM prior to the beginning of Option Period 1 and residing outside of PSAs under this contract may enroll to a PSA PCM at the beginning of Option Period 1, provided the beneficiary resides less than 100 miles from an available network primary care manager in the PSA, submits a new request for enrollment and waives both primary and specialty care travel time standards. Beneficiaries enrolled in Prime to a civilian PCM prior to the beginning of Option Period 1 who reside outside of PSAs under this contract and are 100 miles or more from an available PCM in the PSA network shall not be permitted to continue their enrollment.

E.4. The Contractor shall grant a request for a new enrollment to the network from a beneficiary residing outside a PSA provided there is sufficient unused network capability and capacity to accommodate the enrollment, the PSA network primary care manager to be assigned is located less than 100 miles from the beneficiary's residence, and the beneficiary waives both primary and specialty care travel time standards.

E.5. The MTF Commander may grant exceptions to the requirement to enroll all beneficiaries to the MTF prior to enrollment to the Contractor's network. Such instances should be rare and should be based on valid clinical capability to meet the individual health care needs of the patient.

E.6. The Contractor shall accept payment of Prime enrollment fees on a monthly, quarterly, or annual basis and shall provide payment methods for enrollment fees in accordance with the TRICARE Operations Manual, Chapter 6, Section 1. Emphasis should be placed on monthly allotments or monthly electronic funds transfer to the fullest extent possible to minimize beneficiary risk of involuntary disenrollment due to non-payment. The Contractor shall provide beneficiaries with written notice of a payment due and when beneficiaries are delinquent in accordance with the TRICARE Operations Manual, Chapter 6, Section 1.

E.7. The Contractor shall ensure that enrollment during transition phase-in and transfers of enrollment, i.e., portability, as described in the TRICARE Operations Manual are accomplished in a way that ensures uninterrupted coverage for the TRICARE Prime enrollee. During transition, the incoming Contractor shall enroll all TRICARE Prime beneficiaries to their assigned PCM, and maintain the beneficiary's enrollment periods from the preceding Contractor. If a beneficiary's civilian PCM remains in the Contractor's network, the beneficiary may retain their PCM. If the beneficiary must change PCMs, all enrollments shall be to the MTF for enrollees residing within drive-time standards until MTF capacity is reached, as determined by the MTF Commander.

CUSTOMER SERVICE

CS.1. The Contractor shall provide comprehensive, readily accessible customer services that includes multiple, contemporary avenues of access (for example, e-mail, World Wide Web, telephone, and facsimile) for the MHS beneficiary. Customer services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers.

CS.2. The Contractor shall meet with and establish a MOU with TMA Communications and Customer Service Directorate (C&CS) in accordance with the TRICARE Operations Manual, Chapter 11. The MOU shall address all interface requirements necessary to effectively administer the program. The Contractor shall partner and collaborate with C&CS on the identification and development of education materials required to support the accomplishment of the Education Plan submitted in accordance with Section F.

CS.2.1. The Contractor shall use the Government's national suite of TRICARE educational materials pertaining to specific aspects of the TRICARE benefit and programs. The Contractor shall use the Government's mandatory formats to ensure the one look and feel of all regional educational material. The Contractor will produce regional provider education material in accordance with the TRICARE Operations Manual, Chapter 11 that must be reviewed by the TRO and concurred with by the Contracting Officer.

CS.3. The Contractor shall use best commercial practices and technology that meet the needs of the MHS beneficiary in establishing a customer service presence in accordance with TRICARE Operations Manual, Chapter 11, for all MHS eligible beneficiaries at each MTF in Attachment J-3, Mandatory TSC Locations, either within the MTF or on the base. These sites shall be named TRICARE Service Centers (TSCs) regardless of the extent of services offered. Attachment J-3 describes any space that an MTF has available to the Contractor. Where the space is insufficient to support all TSC activities, the Contractor shall establish those customer service activities not available on site in a manner that is convenient to beneficiaries and provides the highest service levels. The Contractor shall maintain a sufficient supply of TRICARE education materials at each TSC to adequately support information requests. The Contractor shall request educational information on the VA and CHAMPVA through the VA Health Administration Center in sufficient quantities to support TSC operations. [The Contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.] The Contractor shall provide TSC services during periods when access to the TSC physical space is limited or terminated as a result of weather, war, security, or MTF/Installation Commander's decision.

CS.3.1. The Contractor shall deploy mobile Service Assist Team (SATs) necessary to perform customer service functions to disaster areas, Active Component and Reserve Component troop mobilization areas, BRAC areas, or to any area deemed necessary and requested by the Regional Director (RD). A modification will be issued by the Contracting Officer defining the requirement for each SAT. SATs shall be deployed on an as needed basis for a finite period of time as defined in the modification. Within seven calendar day notice, the Contractor shall deploy one or more teams. Service Assist Teams shall provide services similar to those offered at a TRICARE Service Center and, at a minimum, will provide assistance with beneficiary enrollment, assistance with access to and referral for care, and providing TRICARE program information.

CS.4. The Contractor shall provide customer service support equal to forty person-hours per month for each MTF listed in Attachment J-1, Government Required MTF PRIME Service Areas, to be used at the discretion of and for the purpose specified by each MTF Commander. Examples of possible uses of this time include in-processing briefings/enrollments, TRICARE briefings, and specialty briefings on specific components of TRICARE or focused to a specific subset of TRICARE beneficiaries. This is in addition to the requirements for briefings and attendance at meetings specified in the TRICARE Operations Manual, Chapter 11. The Contractor shall provide customer service support equal to forty person-hours per month to be used at the discretion of and for the purpose specified by the Regional Director. The forty person-hours for each MTF Commander and each Regional Director may be used at various locations and outside normal business hours. Unused hours from one month will not be carried over to subsequent months.

CS.5. The Contractor shall provide assistance in accessing information about other Department of Defense programs and applicable community/state/federal health care and related resources for all MHS eligible beneficiaries who require benefits and services beyond TRICARE. The Contractor shall maintain Resource Guides that describe DoD programs and applicable community, state and federal health care which shall be available to TSC personnel to provide to beneficiaries. These resource guides will be updated quarterly.

CS.6. The Contractor shall perform all customer service functions with knowledgeable, courteous, responsive staff that results in highly satisfied beneficiaries.

CLAIMS PROCESSING

CP.1. The Contractor shall establish, maintain, and monitor an automated information system to ensure claims are processed in an accurate and timely manner, and meet the functional system requirements as set forth in the TRICARE Operations Manual and the TRICARE Systems Manual. The claims processing system shall be a single data base and be HIPAA compliant.

CP.2. The Contractor shall ensure that TRICARE claims (including adjustments) are timely and accurately adjudicated for all care provided to beneficiaries in accordance with the timeliness and quality standards of the TRICARE Operations Manual, Chapter 1, Section 3.

CP.3. The Contractor shall, as one means of electronic claims submission, establish and operate a system for two-way, real time interactive Internet Based Claims Processing (IBCP) by providing web based connectivity to the claims/encounter processing system for both institutional and non-institutional claims processing. This IBCP system shall provide immediate eligibility verification by connectivity to Defense Enrollment Eligibility Reporting System (DEERS) and provide current deductible, Catastrophic Cap, and cost share/co-payment information to the provider online by connectivity to the DEERS catastrophic loss protection function and connectivity to the authorization system. The IBCP system shall comply with Department of Defense Information Assurance Certification and Accreditation Process (DIACAP) and encryption requirements. At no additional cost to the Government, the Contractor shall regularly update the IBCP system to utilize newer encryption security protocols. The IBCP must be available for benchmark testing (see the TOM, Chapter 1, Section 7).

CP.4. The following percentage of all claims shall be submitted electronically after the specified percentage of claims has been excluded. For the West Region 28% of paper claims will be excluded each option period from the total number of paper claims processed.

ELECTRONIC CLAIMS PROCESSING STANDARDS

Option Period	West
1	83%
2	84%
3	85%
4	86%
5	87%

Note: The standards listed above supercede and replace the standards included in TOM, Chapter 1, Section 3, paragraph 1.4. The TOM will be updated in the near future to reflect the revised standards.

CP.5. The Contractor's claims processing system shall interface with and accurately determine eligibility and enrollment status based on the DEERS in accordance with the TRICARE Systems Manual.

CP.6. The Contractor's claims processing system shall accurately process claims in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, the TRICARE Policy Manual, and TRICARE Reimbursement Manual. The Contractor's claims processing system shall correctly apply deductible, co-pay/coinsurance, cost shares, catastrophic cap, authorization requirements, and point-of-service provisions in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, 199.17 and 199.18, the TRICARE Policy Manual, and TRICARE Reimbursement Manual. The Contractor's claims processing system shall accurately coordinate benefits with other health insurances to which the beneficiary is entitled as required by 32 CFR 199.8, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

CP.7. Claims requiring additional information shall be returned or developed for the missing information. The Contractor shall ensure that all required information is requested with the initial return or development action and that no claim is returned/developed for information that could have been obtained internally or from DEERS. The Contractor shall ensure that an adequate audit trail is maintained for all returned or denied claims.

CP.8. The Contractor shall ensure non-network/non-participating claims received more than 12 months after the date of service are denied unless the requirements contained in 32 CFR 199.7 are met. Timely filing requirements for network providers shall be governed by the network provider agreement, but shall not exceed 12 months from date of service (or discharge).

CP.9. The South Region Contractor shall manage enrollments, collect premiums, accurately identify and adjudicate claims and perform all requirements involving Continued Health Care Benefit Program according to the TRICARE Policy Manual.

CP.10. The Contractor shall accurately reimburse network and non-network provider claims in accordance with applicable statutory (United States Code, Chapter 55, Title 10) and regulatory provisions (32 CFR 199.14) and with the TRICARE Policy Manual and TRICARE Reimbursement Manual. The Contractor will reimburse network providers in accordance with the payment provisions contained in the provider agreement/contract. The Contractor's reimbursement to network providers shall not exceed the amount which would have been reimbursed using the TRICARE payment methodologies and limits contained in 32 CFR 199.14, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

CP.11. The Contractor shall provide an Explanation of Benefits (EOB) to each beneficiary and provider as described in the TRICARE Operations Manual, Chapter 8. The EOB must clearly describe the action taken on the claim or claims; provide information regarding appeal rights, including the address for filing an appeal; information on the deductible and catastrophic cap status following processing and sufficient information to allow a beneficiary to file a claim with a supplemental insurance carrier. HIPAA-compliant electronic remittance advices shall be returned to providers who submit claims via HIPAA-compliant standard electronic transactions.

CP.12. The Contractor shall accurately capture and report TRICARE Encounter Data (TED) related to claims adjudication in accordance with the provisions of the TRICARE Systems Manual and shall ensure the standards contained in this contract are achieved according to the TRICARE Operations Manual. All TED records shall comply with the information management requirements of this contract and shall be reported in compliance with the standards in the TRICARE Operations Manual.

CP.12.1. The Contractor shall submit information on all providers authorized by the Contractor, to the TRICARE Management Activity centralized TRICARE Encounter Provider Record system in accordance with the provisions of the TRICARE Systems Manual.

CP.13. The Contractor shall furnish to any TMA designated site(s) and all Health Benefits Advisors, Beneficiary Counseling and Assistance Coordinators, and Debt Collection Assistance Officers located in each region (approximately 1,000 accounts per region) with read only access to claims data. The Contractor shall provide training and ongoing customer support for this access.

CP.14. The Contractor shall process claims for pharmaceuticals to beneficiaries in a health care setting where the pharmaceuticals are not obtained from a retail pharmacy. Pharmaceuticals obtained by a beneficiary from a retail pharmacy, the TRICARE Mail Order Pharmacy, or from specialized pharmacies as a component of the consolidated retail pharmacy benefit are not the responsibility of the Contractor. See TRICARE Operations Manual, Chapter 8, Section 2, for additional claims jurisdiction information.

MANAGEMENT

MGT.1. The Contractor shall establish and maintain experienced and qualified key personnel and sufficient staffing and management support to meet the requirements of this contract.

MGT.2. The Contractor shall establish and continuously operate an internal quality management/quality improvement program covering every aspect of the Contractor's operation, both clinically and administratively. The Contractor shall provide a quarterly briefing in person or via video teleconference to the COR and TMA staff on the Contractor's ongoing internal quality improvement program. The Contractor shall also comply with the vulnerability assessment requirements of the TRICARE Operations Manual, Chapter 1.

MGT.3. The Contractor shall ensure that all network providers, TRICARE-authorized providers and their support staffs in the region gain a sufficient understanding of applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner which promotes beneficiary satisfaction. The Contractor shall have the responsibility for delivering necessary information to network providers in their region. The Contractor shall determine the requirements for printed products for network providers and will develop and deliver these products upon review by the TRO and concurrence of Contracting Officer. The information in these products will be determined by the Contractor based on their understanding of the needs of their providers in their region. The Government may measure provider satisfaction with Contractor provided information by conducting random satisfaction surveys of select network providers in accordance with TRICARE Operations Manual, Chapter 11. The Contractor shall use the "one look and feel" format provided by the Government and shall submit all educational material to the Contracting Officer for review and concurrence prior to printing and provider distribution.

MGT.4. The Contractor shall collaborate with the Regional Director and MTF Commanders to ensure the most efficient mix of health care delivery between the direct care system and the Contractor's network within their region. Collaboration includes, but is not limited to, right of first refusal for referrals for all or designated specialty care, including ancillary services and coordinated preventive health care. The Memorandum of Understanding (drafted by the Contractor) between each Regional Director, MTF Commander, and the Contractor shall be in writing and must be approved by the Contracting Officer. The Contractor shall initiate discussions related to and prepare the MOU. (See the TRICARE Operations Manual, Chapter 15).

MGT.5. The Contractor shall ensure that all Contractor personnel working in DoD MTFs meet the MTF-specific requirements of the facility in which they will be working and comply with all local Employee Health Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Blood Borne Pathogens (BBP) Program requirements. This includes any MTF required training for Contractor personnel.

MGT.6. The Contractor shall develop and implement, in conjunction with each MTF and the Regional Director, a contingency program designed to ensure that health care services are continuously available to TRICARE eligible beneficiaries as the MTFs respond to war, operations other than war, deployments, training, contingencies, special operations, and natural disasters. The draft contingency program plan shall be provided to the Government for approval 120 days prior to the start of health care delivery and the documented contingency program shall be provided to the Government 60 days prior to the start of health care delivery and updated annually thereafter.

MGT.6.1. The Contractor shall implement the contingency program at any and all affected locations within forty-eight (48) hours of being notified by the Contracting Officer or Regional Director that a contingency exists.

MGT.6.2. The Contractor shall participate in each MTF's Installation Level Contingency Exercise twice each calendar year. The purpose of the exercise is to test the contingency program under a variety of situations and to provide information from which the Contractor's contingency program shall be updated. The Contractor shall also participate in Regionally Coordinated Table Top Contingency Exercises twice each year.

MGT.7. The Contractor shall participate, in person, in round table meetings/summits with the Government, all other Managed Care Support Contractors, and any other participants that the Government determines are necessary twice each calendar year. The round table meetings/summits requires high level managerial participation from the Contractors (CEOs, Medical Directors, Operations) and participation, in person, by the Contractor's technical and cost experts as determined by the agenda. The round table meetings/summit participants are tasked with reviewing current policies and procedures to determine where proven best practices from the participants' Government and private sector operations can be implemented in the administration of TRICARE to continue TRICARE's leading role as a world-class health care delivery system.

MGT.8. The Contractor shall locate a senior executive with the authority to obligate the Contractor's resources within the scope of this contract within a fifteen-minute drive of the TRICARE Regional Office.

MGT.9. The Contractor shall implement processes and procedures that ensure full compliance with the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities. (See http://www.hcqualitycommission.gov/.)

MGT.10. At midnight Pacific Time on the last day of health care delivery under this contract, the Contractor shall assign its rights to the telephone number serving the region to the incoming MCS Contractor.

MGT.11. The Contractor shall encourage all acute-care medical/surgical hospitals in the Contractor's provider networks to become members of the National Disaster Medical System (NDMS).

MGT.12. The Contractor shall provide to authorized Government personnel (as determined by the Contracting Officer) access to ALL data at the beneficiary, non-institutional and institutional level, with immediate access to the Contractor's full set of data associated with TRICARE. Minimum access shall include two authorizations at each MTF, two authorizations at each Multi-Service Market Office, two authorizations at each Surgeon General's Office, two authorizations at the Regional Director's Office, two authorizations at Health Affairs, two authorizations at TMA-Northern Virginia, two authorizations at TMA-Aurora, and authorization for each on-site Government representative. The Contractor shall make available an additional 15 authorizations to be assigned at the discretion of the Government. The Contractor shall provide training and ongoing customer support for this access. The data shall include, at a minimum, data concerning the provider network, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, and incurred cost data. All data must be current, accurate, complete and accessible immediately. Complete information includes all data pertaining to the execution of Prime, Extra and Standard benefits both inside and outside Prime service areas. Ad hoc reports must satisfy the user's requirement within the time frames agreed upon by the Government and the Contractor. Search capabilities must be built into systems and must be user friendly. Web based training is acceptable; however it must be updated as system changes occur and must be on-going. The data shall be, at a minimum, available for queries on a Regional, MTF Prime Service Area, and standard geographic area (State, County, and Zip Code) basis. The data access interface will be mutually agreed upon by the TRO and MCS Contractor and available by start of health care delivery.

MGT.13. The Contractor shall provide information management and information technology support as needed to accomplish the stated functional and operational requirement of the TRICARE program and in accordance with the TRICARE Systems Manual

MGT.14. The Contractor shall enter into a Data Use Agreement (DUA) for data obtained from DoD Systems and applications and comply with DoD 6025.18-R, DoD Health Information Privacy Regulation, HIPAA Privacy Rule, and DoD 5400.11-R DoD Privacy Program, by submitting a DUA to the Privacy Office annually or until its contract is no longer in effect, as required in the TRICARE Systems Manual and TRICARE Operations Manual.

MGT.15. The Contractor shall ensure its subcontractors and/or their agents who require the use of or access to individually identifiable information or protected health information under the provisions of this contract comply with DoD regulations and the TRICARE Systems Manual.

MGT.16. Personnel Security. The Contractor shall coordinate with the Government to ensure compliance with the Personnel Security Program of DoD 5200.2-R and the TRICARE Systems Manual, Chapter 1. The Contractor shall initiate and document all activities necessary to ensure compliance with the Personnel Security Program of DoD 5200.2-R and the TRICARE Systems Manual, Chapter 1. The Contractor shall also ensure all personnel, to include subcontractors and/or their agents, comply with all system access requirements including initial and refresher training at intervals designated by the Government.

MGT.16.1. System Security. The Contractor shall acquire, develop and maintain the DoD Information Assurance Certification and Accreditation Process (DIACAP) documentation to ensure both initial and continued DIACAP Certification and Accreditation (C&A) for all Contractor/subcontractor systems/networks processing or accessing Government sensitive information (SI) as required by TSM, Chapter 1. The Contractor shall cooperate with and assist the Government's (MHS) DIACAP C&A Team during all phases of the C&A process by providing documentation in accordance with the MHS DIACAP C&A team schedule. The Contractor shall also put in place processes that meet the requirements of the TSM, Chapter 1 to ensure at least a Mission Assurance Category III (MAC III) Sensitive level of security protection for systems/networks that process MHS SI under this contract. DIACAP certification generally takes 6 to 9 months to achieve and the Contractor shall plan the certification activity that results, at a minimum, in an Interim Authority To Operate (IATO) prior to accessing DoD data or interconnectivity with the Government systems and testing. (See DoD 8500.2 (Information Assurance Implementation) and DoD 8510.01.)

MGT.16.2. The Contractor shall comply with DoD Information Assurance (DoD Directive 8500.1), MAC III, Sensitive Requirements found in DoD Information Assurance Implementation (DoD Instruction 8500.2), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (DoD 5200.2-R) and the MHS AIS Security Policy Manual. The Contractor shall also comply with OMB M-06-16, Protection of Sensitive Agency Information. The Contractor shall comply with DoD Minimum Security Requirements as outlined in the TSM, Chapter 1.

MGT.16.3. The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS), the DoD Health Information Privacy Regulation (DoD 6025.18- R) the Health Insurance Portability and Accountability Act Security Compliance Memorandum (Health Affairs Policy 06-010), the Security Standards for the Protection of Electronic Protected Health Information and the requirements in the TOM, Chapter 19, and the TSM, Chapter 1.

MGT.16.4. The Contractor shall ensure that all electronic transactions comply with HIPAA rules and regulations and TMA requirements in the TSM, Chapter 1 and the TOM, Chapter 19.

MGT.16.5. Pursuant to FAR Part 24 the requirements of the Privacy Act (5 U.S.C. 552a) and the Department of Defense Privacy Program (DoD 5400.11-R) are applicable to this contract and the systems of records operated and maintained by the Contractor on behalf of the TMA. These systems of records are found at 65 Federal Register 30966 (Health Benefits Authorization Files, Medical/Dental Care and Claims Inquiry Files, Medical/Dental Claim History Files), 60 Federal Register 43775 (USTF Managed Care System), 69 Federal Register 50171 and 71 Federal Register 16127 (Military Health Information System), and 64 Federal Register 22837 (Health Affairs Survey Data Base). The records systems operated and maintained by the Contractor are records systems operated and maintained by a DoD Component (TMA). (See TOM, Chapter 1, Section 5, Chapter 2, Section 1, and Chapter 2, Section 2).

MGT.17. The Contractor may enter into Clinical Support Agreements (CSAs) in order to optimize the MTF (reference the TOM, Chapter 15, Section 3). The Contracting Officer will incorporate CSAs by modification to the contract.

MGT. 18. The MCSC and the TRICARE Pharmacy Contractor shall establish a Memorandum of Understanding (MOU) for the purpose of addressing necessary cooperation, exchange of information, and points of contact for such things as pharmacy utilization data, program integrity issues, case management (including coordination of care for patients who are enrolled in specialty pharmacy services), third-party liability, and claims jurisdiction issues. The MOU will specifically address the frequency and format of pharmacy utilization data which will be provided to the MSCS by the TRICARE Pharmacy Contractor.

MGT.19 Proper Identification of Contractor Personnel

MGT.19.1 Contractors, including subcontractor at all tiers, shall provide for a clear distinction from Government personnel. Contractor employees shall not act, advertise, or presume to be Government employees, agents, or representatives. Contractor employees are required to appropriately identify themselves as contractor employees at all times, including in telephone conversations, formal and informal written correspondence, paper and electronic; and in any other situation where their actions could be construed as acts of Government officials unless, in the judgment of the Government, no harm can come from failing to identify themselves. Contractor employees shall be introduced as contractor personnel and display distinguishing visible identification at all times whether in conversations, meetings, and other forms of communication with Government personnel.

MGT.19.2 Contractor personnel, while performing in a contractor capacity, shall refrain from using their retired or reserve component military rank or title in written or verbal communications associated with the contracts for which they provide services.

MGT.19.3 The contractor shall incorporate the substance of this requirement in all subcontracts awarded under this contract.

D.1. PACKAGING

Preservation, packaging, and packing for shipment or mailing of all work delivered hereunder, by other than electronic means, shall be in accordance with good commercial practice and adequate to insure acceptance by common carrier and safe transportation at the most economical rate(s). The Contractor shall not utilize certified or registered mail or private parcel delivery service for the distribution of reports under this contract without the advance approval of the Contracting Officer. CD-ROMs (or other electronic media) shall be packed in labeled cartons in accordance with the best commercial practices that meet the packing requirements of the carrier and ensure safe delivery at the destination.

D.2. MARKING

Each package, report or other deliverable shall be accompanied by a letter or other document which:

D.2.1. Identifies the contract by number under which the item is being delivered.

D.2.2. Identifies the deliverable Item Number or Report Requirement which requires the delivered item(s).

D.2.3. Indicates whether the Contractor considers the delivered item to be a partial or full satisfaction of the requirement.

E.1 52.246-4 INSPECTION OF SERVICES–FIXED-PRICE (AUG 1996)

E.2 52.246-5 INSPECTION OF SERVICES–COST-REIMBURSEMENT (APR 1984)

E.3 52.246-6 INSPECTION OF SERVICES—TIME-AND-MATERIAL AND LABOR HOUR (MAY 2001)

E.4 252.246-7000 MATERIAL INSPECTION AND RECEIVING REPORT (MAR 2008)

E.5. INSPECTION LOCATIONS

Inspections may be conducted electronically or by physical inspection. Inspections will be performed at the TRICARE Management Activity (TMA), the Contractor's and/or subcontractor's facilities, or any other locations at which work is performed. Inspection of services provided hereunder will be accomplished by the Contracting Officer or his/her designee(s).

E.6. ACCEPTANCE

E.6.1. Claim Processing (Paper & Electronic): The Contractor shall submit a TED record for each health care claim processed. The inspection process of claims processing services will begin at the TEDs batch header level by the TMA TED system through the individual TED record level. Acceptance will be accomplished by individual TED record. Payment of the claims processing fees for a TED record demonstrates formal acceptance.

E.6.2. Transition-In and Transition-Out: The Contractor shall submit one DD250, Material Inspection and Receiving Report after accomplishing the required Transition-In and Transition-Out requirements, respectively. The DD250 shall be sent to the Contracting Officer's Representative with a copy provided to the Contracting Officer.

E.6.3. Formal acceptance or rejection of all other services provided under the terms and conditions of this contract will be accomplished by the Contracting Officer or Contracting Officer's Representative on an annual basis after each option period using a DD250, Material Inspection and Receiving Report. The Contractor shall submit a DD250 after accomplishing all required services in each respective option period. The DD250s shall be sent to the Contracting Officer's Representative with copies provided to the Contracting Officer.

F.1. 52.242-15 STOP-WORK ORDER (AUG 1989)

F.2. 52.242-15 I STOP-WORK ORDER (AUG 1989)–ALTERNATE I (APR 1984)

F.3. PERIOD OF PERFORMANCE

F.3.1. Base Period (Date of Award to start of health care delivery): The Contractor shall begin transition-in activities and complete specific activities by the timelines specified in the TRICARE Operations Manual (TOM) Chapter 1, Section 7. All transition-in activities shall be completed by the date specified in the Contractor's Start-Up/Transition Plan.

F.3.2. Option Periods 1 through 5 will be 12 months each if exercised.

Option Period 1: April 1, 2013 through March 31, 2014

Transition-Out Option (if applicable)

Option Period 2: April 1, 2014 through March 31, 2015

Transition-Out Option (if applicable)

Option Period 3: April 1, 2015 through March 31, 2016

Transition-Out Option (if applicable)

Option Period 4: April 1, 2016 through March 31, 2017

Transition-Out Option (if applicable)

Option Period 5: April 1, 2017 through March 31, 2018

Transition-Out Option (if applicable)

F.3.3. The option periods identified herein are hereby defined as the period in which health care is delivered to TRICARE beneficiaries. The start of health care delivery is the first day of Option Period 1. In order to meet the requirements of the contract for health care delivered for a given period, the Contractor will be performing incidental administrative tasks associated with the given health care delivery period beyond that period.

F.3.4. The transition-out period may be exercised during any one of the health care delivery periods specified above. The Contractor will begin transition-out activities upon transition-out option exercise and complete the timelines as specified in TOM Chapter 1, Section 7. All transition-out activities shall be accomplished no later than 270 days after the start of health care delivery for the incoming Contractor(s).

F.4. GEOGRAPHIC AREA OF COVERAGE

F.4.1. North Contract: The contract shall be referred to as the North Contract. It will require development, implementation and operation of a health care delivery and support system for TRICARE and other Military Health System (MHS) beneficiaries residing in the states of Connecticut, Delaware, District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area only, see F.4.4.1.), Kentucky (except the Ft. Campbell area, see F.4.4.2.), Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area only, see F.4.4.3.), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and Wisconsin. These geographic areas are hereinafter referred to as the North Contract.

F.4.2. South Contract: The contract shall be referred to as the South Contract. It will require development, implementation and operation of a health care delivery and support system for TRICARE and other MHS beneficiaries residing in the states of Alabama, Arkansas, Florida, Georgia, Kentucky (the Fort Campbell area only, see F.4.4.2.), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (excluding areas of Western Texas, see F.4.4.4.). These geographic areas are hereinafter referred to as the South Contract. The South Region Contractor shall be responsible for administering and complying with all Continued Health Care Benefit Program (CHCBP) requirements in all geographic areas.

F.4.3. West Contract: The contract shall be referred to as the West Contract. It will require development, implementation and operation of a health care delivery and support system for TRICARE and other MHS beneficiaries residing in the states of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area, see F.4.4.1.), Kansas, Minnesota, Missouri (except the St. Louis area, see F.4.4.3.), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (areas of Western Texas only, see F.4.4.4.), Utah, Washington, and Wyoming. These geographic areas and states are hereinafter referred to as the West Contract.

F.4.4. For the states identified above that cross regional boundaries, the following zip codes define which portion of the state belongs to which region.

F.4.4.1. The state of Iowa is in the West Region except for the following zip codes (Rock Island area) which are in the North Region:

52030	52306	52721	52739	52757	52776
52031	52309	52722	52742	52758	52777
52037	52320	52726	52745	52759	52778
52060	52321	52727	52746	52760	52801
52064	52323	52728	52747	52761	52802
52069	52337	52729	52748	52765	52803
52070	52358	52730	52749	52766	52804
52074	52362	52731	52750	52767	52805
52075	52637	52732	52751	52768	52806
52207	52640	52733	52752	52769	52807
52212	52646	52734	52753	52771	52808
52216		52736	52754	52772	52809
52254	52701	52737	52755	52773	
52255	52720	52738	52756	52774	

F.4.4.2. The state of Kentucky is in the North Region except for the following zip codes (Ft. Campbell area) which are in the South Region:

42020	42076	42223	42274	42332	42413
42025	42134	42232	42276	42337	42431
42029	42135	42234	42280	42339	42436
42036	42170	42236	42283	42344	42440
42038	42202	42240	42286	42345	42441
42040	42204	42241	42320	42350	42442
42044	42206	42254	42321	42354	42445
42045	42211	42256	42323	42367	42450
42048	42215	42261	42324	42369	42453
42049	42216	42262	42325	42372	42464
42054	42217	42265	42326	42408	
42055	42220	42266	42328	42410	
42071	42221	42273	42330	42411	

F.4.4.3. The state of Missouri is in the West Region except for the following zip codes (St. Louis area) which are in the North Region:

63001	63040	63088	63128	63177	63350
63005	63041	63089	63129	63178	63351
63006	63042	63090	63130	63179	63352
63010	63043	63091	63131	63180	63353
63011	63044	63099	63132	63182	63357
63012	63045	63101	63133	63188	63359
63013	63046	63102	63134	63190	63361
63014	63047	63103	63135	63195	63362
63015	63048	63104	63136	63196	63363
63016	63049	63105	63137	63197	63365
63017	63050	63106	63138	63198	63366

63018	63051	63107	63139	63199	63367
63019	63052	63108	63140	63301	63368
63020	63053	63109	63141	63302	63369
63021	63055	63110	63143	63303	63370
63022	63056	63111	63144	63304	63373
63023	63057	63112	63145	63330	63376
63024	63060	63113	63146	63332	63377
63025	63061	63114	63147	63333	63378
63026	63065	63115	63150	63334	63379
63027	63066	63116	63151	63336	63381
63028	63068	63117	63155	63338	63382
63030	63069	63118	63156	63339	63383
63031	63071	63119	63157	63341	63384
63032	63072	63120	63158	63342	63385
63033	63073	63121	63160	63343	63386
63034	63074	63122	63163	63344	63387
63035	63077	63123	63164	63345	63388
63036	63079	63124	63166	63346	63389
63037	63080	63125	63167	63347	63390
63038	63084	63126	63169	63348	
63039	63087	63127	63171	63349	

F.4.4.4. The state of Texas is in the South Region except for the following zip codes (western portions of the state) which are in the West Region:

79009	79855	79931	79978	88531	88562
79035	79901	79932	79980	88532	88563
79053	79902	79934	79990	88533	88565
79325	79903	79935	79995	88534	88566
79344	79904	79936	79996	88535	88567
79347	79905	79937	79997	88536	88568
79718	79906	79938	79998	88538	88569
79734	79907	79940	79999	88539	88570
79754	79908	79941	88510	88540	88571
79770	79910	79942	88511	88541	88572
79772	79911	79943	88512	88542	88573
79780	79912	79944	88513	88543	88574
79785	79913	79945	88514	88544	88575
79786	79914	79946	88515	88545	88576
79821	79915	79947	88516	88546	88577
79835	79916	79948	88517	88547	88578
79836	79917	79949	88518	88548	88579
79837	79918	79950	88519	88549	88580
79838	79920	79951	88520	88550	88581
79839	79922	79952	88521	88553	88582
79843	79923	79953	88523	88554	88583
79845	79924	79954	88524	88555	88584
79846	79925	79955	88525	88556	88585
79847	79926	79958	88526	88557	88586
79849	79927	79960	88527	88558	88587
79851	79928	79961	88528	88559	88589
79853	79929	79968	88529	88560	88590
79854	79930	79976	88530	88561	88595

F.5. REPORTS AND PLANS

Unless otherwise specified, the Contractor shall electronically submit all Contract Data Requirements List items (CDRL) (contract plans, reports, etc.) in the specified format using Microsoft Office Excel, Word, PDF, or other specified software. If no format is specified, the Contractor may use its own format. Unless otherwise specified, all CDRL items shall be submitted to the Government via the E-commerce Extranet (https://tma-ecomextranet.ha.osd.mil/logon/logon.cfm). (See the TOM, Chapter 14, Section 2, for report submission requirements.)

F.5.1. The Contractor shall provide all reports and plans that are specified in this Section. The Contractor is accountable for assuring that reports contain accurate and complete data. The Contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. All reports must be supported with sufficient documentation and audit trails. The reports shall be titled as listed. The Contractor shall submit a negative report if there is no data to report. Required reports include:

F.5.1.1. Daily Reports

D010 Non-Financially Underwritten Contractor Payment/Check Issue Report
D020 Financially Underwritten Contractor Payment/Check Issue Report

F.5.1.2. Weekly Reports

W010 Claims Aging Report by Status/Location
W020 Incoming Contractor Weekly Status Report
W030 Outgoing Contractor Weekly Status Report
W040 Supplemental Health Care Program (SHCP) Aging Claims Report
W050 Claims Processing Statistics Report
W060 Purchased Care Active Duty Inpatient Census Report

F.5.1.3. Monthly Reports

M010 Toll-Free Telephone Report
M020 Enrollment Plan Implementation Report
M030 TRICARE Quality Monitoring Contract (TQMC) Findings Response Report
M040 Clinical Quality Management (CQM) Monthly Quality Issues Report
M050 Right of First Refusal Referrals Report
M060 Customer Satisfaction Report
M070 Education Presentation Report
M080 Debt Collection Assistance Officer Program Collection Report
M090 Clinical Support Agreement Reports
M100 HIPAA Privacy Disclosure Report
M110 TRICARE Reserve Select (TRS) Premium Activity Report
M170 Beneficiary Services Report
M180 Case Management/Disease Management Report
M190 Cycle Time/Aging Report
M200 Workload Report
M210 Medical Management Report
M220 Network Adequacy Report
M230 Network Inadequacy Report
M240 Non-Financially Underwritten Accounts Receivable Report including Supplemental Reports
M250 Non-Financially Underwritten Bank Account Reconciliation Report
M260 Non-Financially Underwritten Bank Cleared Payment Report
M270 Financially Underwritten Bank Cleared Payment Report
M280 Non-Financially Underwritten Bank Account Statement Report
M290-Autism Services Demonstration Report
M300 TQMC Monthly Validation Report
M301 POA Indicators and HACs Monthly Report

F.5.1.4. Quarterly Reports

Q010 Claims Audit Report
Q020 Retrospective Review Requirements for Other than Diagnostic Related Group (DRG) Validation Report
Q030 Beneficiary Access Assistance Report
Q040 Congressional and Health Benefits Advisor (HBA) Relations Report
Q050 Procedure Code Unbundling Report
Q060 Prepayment Pre-encounter Screens Report
Q070 Fraud and Abuse Summary Report
Q080 Utilization Management Report
Q090 Management of Myelomeningocele Study Report
Q100 Evolving Practices Report

Q110 Network Directory Report
Q120 Appeals Quality Assessment Report
Q130 Grievances Quality Assessment Report
Q140 Written Correspondence Quality Assessment Report
Q150 Telephonic Responses Quality Assessment Report
Q160 Behavioral Health Provider Location and Assistance
Q170 Quarterly Autism Services Demonstration Report

F.5.1.5. Semiannual Reports

S010 DoD Cancer Clinical Trial Report
S020 Semiannual Autism Services Demonstration Report

F.5.1.6. Annual Reports

A010 Clinical Quality Management Report
A020 Third Party Recoveries for Region Fiscal Year Report
A030 Fraud Prevention Savings Report
A040 Alaska Clinical Quality Management Report (West Region Only)
A050 Mental Health Rates Report
A060 Indirect Medical Education (IDME) Ratios for Children's Hospitals Report
A070 Listing of High Volume Providers Report
A080 Listing of Prime Service Area (PSA) Zip Codes
C020 Statement on Auditing Standards (SAS) No. 70

F.5.1.7. Annual Plans

P020 Enrollment Plan
P030 Utilization Management Plan
P040 Clinical Quality Management Program (CQMP) Plan
P050 Education Plan
P060 External Resource Sharing Plan
P070 Alaska Clinical Quality Management Program (CQMP) Plan (West Contract Region Only)
P080 Alaska Utilization Management Plan (West Contract Region only)
P090 Contingency Program Plan
P100 Disease Management Program Plan
P110 Internal Quality Management/Improvement (QM/QI) Program Plan

F.5.1.8. As Required Plans/Reports

R010 Start-Up Plan
R011 Network Implementation Plan
R020 Serious Reportable Events
R040 Accreditation Reports and Documentation
R050 Service Assist Team After Action Report

F.6. CONTRACT PHASE-IN DELIVERABLES

No later than 30 calendar days after contract award, the Contractor shall forward one copy of a Freedom of Information Act (FOIA) releasable contract to the TMA-Aurora FOIA Officer at the following address: TMA, Attention: FOIA Officer, 16401 East CentreTech Parkway, Aurora, CO 80011-9066. The Contractor shall line through all information in the contract which the Contractor determines is not releasable under FOIA. The Contractor will also include a legal analysis which supports the Contractor's determination regarding the non-releasable portions of the contract.

The following deliverables are due during the base period of the contract (reference TOM, Chapter 1, Section 7):

F.6.1. The Transition Plan is due no later than 10 calendar days following contract award.

F.6.2. The Revised Transition Plan is due no later than 15 calendar days following the transition interface meetings.

F.6.3. Executed MOUs with all Military Treatment Facility (MTF) Commanders no later than 60 calendar days prior to the start of health care delivery.

F.6.4. Executed MOU with TMA C&CS within 30 days of the C&CS MOU meeting.

F.6.5. Public Notification/Congressional Mailing to TMA for review no later than 90 calendar days prior to the start of health care delivery.

F.6.6. Demonstration of web-based services and applications no later than 15 days prior to the start of health care delivery.

F.6.7. Commencement of benchmark testing no later than 120 days prior to the start of health care delivery.

F.6.8. Benchmark TRICARE Encounter Data (TED) submissions no later than seven days following the last day of the benchmark test.

F.6.9. Demonstration of call center and TSC staff competency no later than 15 days prior to the start of health care delivery.

F.6.10. Claims Processor Data shall be provided, to include the data described in paragraphs F.6.10.2 through F.6.10.4. The Government will make the data available to the external claims audit Contractor.

F.6.10.1. Description of data elements by field position in family history file printout and field definitions for pricing, OHI, authorization, or referral screens.

F.6.10.2. Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions.

F.6.10.3. Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing.

F.6.10.4. Specifications for submission of the provider file, as described in the TRICARE System Manual, Chapter 2, Section 1.2.

F.7. CONTRACT PHASE-OUT DELIVERABLES

The following items shall be provided to the incoming Contractor during the transition-out of the contract.

F.7.1. Transfer electronic file specifications no later than three calendar days following award of a successor contract (reference TOM, Chapter 1, Section 7).

F.7.2. Transfer electronic Automated Data Processing (ADP) files no later than 15 calendar days following the Outgoing Transition Specifications Meeting (reference TOM, Chapter 1, Section 7).

F.7.3. Weekly shipments of beneficiary history files beginning 120 days prior to the start of health care delivery for the successor contract (reference TOM, Chapter 1, Section 7).

F.7.4. Transfer Case Management and Disease Management Files no later than 60 days prior to the start of health care delivery for the successor contract (reference TOM, Chapter 1, Section 7).

F.7.5. Provide copies of MTF MOUs no later than 30 days following the award of a successor contract (TOM, Chapter 1, Section 7).

F.7.6. Transfer Program Integrity Files no later than 30 calendar days prior to the start of health care delivery for the successor contract (reference TOM, Chapter 1, Section 7).

F.7.7. Transfer Provider Certification Files no later than 30 calendar days following the award of a successor contract (TOM, chapter 1, Section 7).

G.1 252.204-7006 BILLING INSTRUCTIONS (OCT 2005)

When submitting a request for payment, the Contractor shall-
(a) Identify the contract line item(s) on the payment request that reasonably reflect contract work performance; and
(b) Separately identify a payment amount for each contract line item included in the payment request.
(End of Clause)

G.2.A. 252.232-7003 ELECTRONIC SUBMISSION OF PAYMENT REQUESTS AND RECEIVING REPORTS (MAR 2008) Applicable to ALL CLINs (except for Health Care Cost and Claims Processing CLINs)

As prescribed in 232.7004, use the following clause:
(a) *Definitions*. As used in this clause—
(1) "Contract financing payment" and "invoice payment" have the meanings given in section 32.001 of the Federal Acquisition Regulation.
(2) "Electronic form" means any automated system that transmits information electronically from the initiating system to all affected systems. Facsimile, e-mail, and scanned documents are not acceptable electronic forms for submission of payment requests. However, scanned documents are acceptable when they are part of a submission of a payment request made using Wide Area WorkFlow (WAWF) or another electronic form authorized by the Contracting Officer.
(3) "Payment request" means any request for contract financing payment or invoice payment submitted by the Contractor under this contract.
(b) Except as provided in paragraph (c) of this clause, the Contractor shall submit payment requests and receiving reports using WAWF, in one of the following electronic formats that WAWF accepts: Electronic Data Interchange, Secure File Transfer Protocol, or World Wide Web input. Information regarding WAWF is available on the Internet at https://wawf.eb.mil/.
(c) The Contractor may submit a payment request and receiving report using other than WAWF only when—
(1) The Contracting Officer authorizes use of another electronic form. With such an authorization, the Contractor and the Contracting Officer shall agree to a plan, which shall include a timeline, specifying when the Contractor will transfer to WAWF;
(2) DoD is unable to receive a payment request or provide acceptance in electronic form;
(3) The Contracting Officer administering the contract for payment has determined, in writing, that electronic submission would be unduly burdensome to the Contractor. In such cases, the Contractor shall include a copy of the Contracting Officer's determination with each request for payment; or
(4) DoD makes payment for commercial transportation services provided under a Government rate tender or a contract for transportation services using a DoD-approved electronic third party payment system or other exempted vendor payment/invoicing system (e.g., PowerTrack, Transportation Financial Management System, and Cargo and Billing System).
(d) The Contractor shall submit any non-electronic payment requests using the method or methods specified in Section G of the contract.
(e) In addition to the requirements of this clause, the Contractor shall meet the requirements of the appropriate payment clauses in this contract when submitting payment requests.
(End of clause)

G.2.B. 252.232-7003 ELECTRONIC SUBMISSION OF PAYMENT REQUESTS AND RECEIVING REPORTS (DEVIATION) (MARCH 2008) Applicable to Health Care Cost and Claims Processing CLINs 1001, 1002, 1007, 1008; 2001, 2002, 2007, 2008; 3001, 3002, 3007, 3008; 4001, 4002, 4007, 4008; and 5001, 5002, 5007, and 5008.

(a) Definitions. As used in this clause--
(1) "Contract financing payment" and "invoice payment" have the meanings given in section 32.001 of the Federal Acquisition Regulation.
(2) "Electronic form" means any automated system that transmits information electronically from the initiating system to all affected systems. Facsimile, e-mail, and scanned documents are not acceptable electronic forms for submission of electronic payment requests. However, scanned documents are acceptable when they are part of a submission of a payment request made using TRICARE Encounter Data System (TEDS).
(3) "Payment request" means any request for contract financing payment or invoice payment submitted by the Contractor under this contract.
(b) Except as provided in paragraph (c) of this clause, the Contractor shall submit payment requests and receiving reports using TEDS. Information regarding TEDS is available on the Internet at http://manuals.tricare.osd.mil/.
(c) The Contractor may submit a payment request and receiving report using other than TEDS; only when--

(1) The Contracting Officer authorizes use of another electronic form. With such an authorization, the Contractor and the Contracting Officer shall agree to a plan, which shall include a timeline, specifying when the Contractor will transfer to TEDS;
(2) DoD is unable to receive a payment request or provide acceptance in electronic form;
(3) The Contracting Officer administering the contract for payment has determined, in writing, that electronic submission would be unduly burdensome to the Contractor. In such cases, the Contractor shall include a copy of the Contracting Officer's determination with each request for payment; or
(4) DoD makes payment for commercial transportation services provided under a Government rate tender or a contract for transportation services using a DoD-approved electronic third party payment system or other exempted vendor payment/invoicing system (e.g., PowerTrack, Transportation Financial Management System, and Cargo and Billing System).
(d) The Contractor shall submit any non-electronic payment requests using the method or methods specified in Section G of the contract.
(e) In addition to the requirements of this clause, the Contractor shall meet the requirements of the appropriate payment clauses in this contract when submitting payment requests.
(End of clause)

G.3. CONTRACT ADMINISTRATION

G.3.1. The Procuring Contracting Officer (PCO) is responsible for the administration of this contract and is solely authorized to take action on behalf of the Government. Unless specified otherwise within this contract, the PCO is referred to as the Contracting Officer. The Contacting Officer for this contract is:

Contracting Officer
Office of the Assistant Secretary of Defense for Health Affairs
TRICARE Management Activity
Acquisition Management & Support
16401 East Centretech Parkway
Aurora, CO 80011-9066

G.3.2. Administrative Contracting Officer (ACO):
Defense Contract Management Agency (DCMA) ACO. The Contracting Officer will delegate a limited number of functions listed in FAR 42 to the DCMA ACO. The Contractor will be provided copies of all delegation letters.

DCMA Twin Cities
DCMAC-ATAP
Norman Pointe II
5600 W. American Blvd, Suite 600
Bloomington, MN 55437-1448
Telephone: (952) 259-5471
FAX Phone: (952) 259-5565

G.3.3. Defense Contract Audit Agency (DCAA) will provide certain audit functions in support of the Contracting Officer and ACO; and will approve vouchers for reimbursement under the Disease Management Contract Line Item Numbers (CLINs).

DCAA Minneapolis Branch Office
250 Marquette Avenue, Suite 525
Minneapolis, MN 55401-1872
Telephone: (612) 343-7750
FAX Phone: (612) 343-7774
or the DCAA office locator at http://apps.dtic.mil/wobin/WebObjects/DCAAzipcode

G.3.4. Contracting Officer's Representative (COR):
(SEE Section I, DFARS Clause 252.201.7000 for definition)

West Region Contracting Officer Representative
Department of Defense
TRICARE Management Activity
16401 E. Centretech Parkway
Aurora, CO 80011-9066

G.3.5. Contractor Points of Contact personnel:

The names and addresses of the Contractor's primary and alternate point of contact (POC) for contract implementation and compliance are as follows:

Primary:
Lori C. McDougal
Chief Executive Officer
UnitedHealth Military & Veterans Services
9701 Data Park Drive, MN006-E200
Minnetonka, MN 55343
Telephone: (b) (6)
FAX Phone:

Alternate:
Arthur R. Miller
Chief Operating Officer
UnitedHealth Military & Veterans Services
9701 Data Park Drive, MN006-E200
Minnetonka, MN 55343
Telephone: (b) (6)
FAX Phone:

G.3.6. Paying office:

Department of Defense
TRICARE Management Activity
ATTN: Contract Resource Management (CRM)
16401 E. Centretech Parkway
Aurora, CO 80011-9066

G.3.6.1. RESERVED

G.4. RESERVED

G.5. RESERVED

G.6. PAYMENT INSTRUCTIONS FOR MULTIPLE ACCOUNTING CLASSIFICATION CITATIONS

In accordance with DFARS PGI 204.7108, this subsection provides instructions to the paying office:

G.6.1. Accounting & appropriation citations: When obligated, any multiple accounting and appropriation citations will be identified in Section B as informational subline items.

G.6.2. Each CLIN is a separate contract type. Payments will be applied at the CLIN or SubLine Item (SLIN) level. The paying office will assign payments to the accounting classification citation(s) based on the anticipated work performance under each CLIN as follows:

G.6.2.1. Where there is a single line of accounting under a CLIN, the payment office will make payments with the funds established for that CLIN. If there is more than one line of accounting within a CLIN, the payment office will determine the appropriate line of accounting to use based on period of performance.

G.7. OTHER INSTRUCTIONS TO PAYING OFFICE

G.7.1. The paying office will follow paying instructions included in any contract modification, including change order definitizations and performance incentive payment modifications.

G.7.2. The due date for making invoice payments to the Contractor is specified in the Prompt Payment clause, FAR 52.232-25, included in this contract (i.e.: 30th day from receipt of proper invoice or acceptance). The Prompt Payment clause with its Alternate I apply to Underwritten Health Care Cost and Disease Management CLINs. For all line items except for Underwritten Health Care Cost, the paying office will make invoice payments on or before the due date, but not earlier than 7 calendar days prior to the due date. For Underwritten Health Care Cost, the paying office should make invoice payments on the 7th calendar day from receipt or acceptance of a proper invoice/voucher. As specified in Alternate I of the Prompt Payment clause, the payment office will use the due date (30th day after receipt of a proper invoice or acceptance) for computing any late payment interest penalties that may apply. For the Underwritten Health Care Cost and Claims Processing CLINs processed using TED system, the completion of the batch TRICARE Encounter Data (TED) submission (end date/time) is sent to TMA will be used to determine the date of receipt. In the event that the payment office is informed of an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, or there are disagreements on the payment amounts, the payment office is not compelled to make payment by the above dates.

G.7.3. Revisions to payment instructions may be made as circumstances require. This may be accomplished by correspondence between the contracting office and the paying office.

G.8. PMPM MILITARY HEALTH SYSTEM (MHS) ELIGIBLE BENEFICIARIES

G.8.1. For the purpose of this CLIN, counts of MHS eligible beneficiaries under the PMPM includes all MHS eligible beneficiaries, underwritten and non-underwritten, with the exception of those covered under Uniformed Services Family Health Plan (USFHP). The contract region's count of MHS eligible beneficiaries under the PMPM CLINs is based on the eligible beneficiary's address as contained in Defense Enrollment Eligibility Reporting System (DEERS). This includes Prime enrollees who may be enrolled in a different region. The count is taken from the MHS Data Repository (MDR) Point-in-Time Extract (PITE). The MDR PITE is derived monthly from the DEERS PITE, which is a snapshot of the DEERS database reflecting beneficiary status and address at the end of each month.

G.8.2. The Government will unilaterally determine the number of MHS eligible beneficiaries prospectively two times for each option period under each PMPM CLIN (including option period 1), once for the first six month period and once for the seventh through twelfth month. This number will be based on an average of six of the seven previous months of eligible beneficiaries as reported above. Using the number of MHS eligible beneficiaries, the Government will calculate the PMPM quantity for the next bi-annual period as follows: The number of MHS eligible beneficiaries multiplied by the number of months (6) equals the number of member months (the quantity). The number of member months is then multiplied by the fixed unit price equals the extended amount for the period.

G.9. INVOICE AND PAYMENT – NON-TEDS

Non-TEDs invoice and vouchers shall be submitted electronically in accordance with G.2 above. A proper invoice must include the elements identified at FAR 32.905, except for interim payments on the Disease Management CLINs.

G.9.1. Transition-In: The Contractor may invoice for interim payment of 50% of the transition-in price upon the start of health care delivery. The Contractor may submit a final invoice (DD 250) for the balance following completion of all transition requirements.

G.9.2. Underwritten Health Care - Fixed Fee: Submit voucher (i.e. SF1034) no more frequently than monthly and only after completion of the given month.

G.9.3. Disease Management: Interim cost reimbursement vouchers (i.e. SF1034) shall be submitted no more frequently than monthly, and only after completion of the given month, to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer. A final adjustment voucher shall be submitted for each option period to the Contracting Officer upon settlement of incurred cost audit and final indirect rates of the respective option period's final cost.

G.9.4. Disease Management – Fixed Fee: Vouchers (i.e. SF1034) shall be submitted no more frequently than monthly to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer only after completion of a given month.

G.9.5. PMPM: Submit invoice no more frequently than monthly and only after completion of the given month for no more than one-sixth (rounded to the nearest dollar) of the extended CLIN amount.

G.9.6. TRICARE Service Centers: Submit invoice no more frequently than monthly and only after completion of the given month.

G.9.7. Award Fee: The Contractor shall invoice as instructed by the Contracting Officer following determination of any award fee.

G.9.8. Performance Incentive Pool: The Contractor shall invoice as instructed by the Contracting Officer following determination of any performance incentive amounts.

G.9.9 Transition-Out: Interim cost reimbursement vouchers (i.e. SF 1034) shall be submitted no more frequently than monthly, and only after completion of the given month, to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer.

G.9.9.1 Tranisition-Out Fixed Fee: The contractor may submit a voucher (i.e. SF1034) to the cognizant Defense Contract Audit Agency (DCAA) office for approval with a copy provided to the Contracting Officer for the fixed fee upon completion of all transition-out requirements.

G.9.10. Modifications: The Contractor may invoice for change order definitizations, Clinical Support Agreements, Service Assist Teams, or other modifications after the Contracting Officer provides instructions and authorization to invoice via modification.

G.10. INVOICE AND PAYMENT – CLAIMS PROCESSING CLINs

G.10.1. Invoice and payment procedures for claims processing fee are the same for paper and electronic claims. Submission of a TED record header to TMA is considered submittal of an invoice. For purposes of determining the due date for payment under the Prompt Payment Clause, the header "end date/time" TRICARE Encounter Data (TED) submission is sent to TMA will be used to determine the date of receipt.

G.10.2. Claim Quantity: The Contractor is paid the unit price for each initial submission TED record (as defined under TSM Chapter 2, Section 1.1) that passes all TED edits as specified in the TSM and validated by the TMA TED record edit system, plus the Contractor's first adjustment TED record accepted under this contract that was initially submitted by a predecessor contractor.

G.10.3. Unit Price and Performance Period: The Contractor is paid the claims processing unit price identified in Section B for the contract period in which the Contractor submits the initial TED record. The Batch/Voucher date in the voucher header is used to determine the contract period and applicable unit price.

G.10.3.1. Payments for claims the Contractor receives within 120 calendar days following the cessation of health care delivery (for services rendered during the health care delivery period) are made based on the claim processing fee unit price in effect during the health care delivery period immediately preceding transition-out. In order for the Contractor to receive payment of a claims processing fee, the TED record must be accepted by TMA no later than 210 days following the end of health care delivery.

G.10.4. Invoice Instructions: The Contractor shall submit batch/vouchers under the correct "Header type Indicator" as specified in the TRICARE Systems Manual (TSM), Chapter 2, Section 2.3.

G.10.5. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the Contractor may submit invoices outside of the TED system to the Contracting Officer. The invoice shall list the number of claims processed by CLIN. This may be submitted daily or grouped by no more than 5 days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

G. 10.6. Retraction, or collection, of claim processing fee previously paid to the Contractor occurs if 'Header Type Indicator' of '5' or '0' is used. Proper use of 'Header Type Indicator' is defined below:

G. 10.6.1. Ineligible TED Records: If the TED record submitted is not eligible to receive payment under the claims processing CLIN (the contract terms/conditions do not authorize payment of the claims processing fee on a TED record), the contractor shall submit the TED record to the TRICARE Management Activity (TMA) using a Header Type Indicator of '0' or '5'. No payment under the claims processing CLIN can occur on any TED record grouped in a Batch/Voucher with Header Type Indicator of '0' or '5'. Only no-pay and credits can be processed under these header types.

G. 10.6.2. Eligible TED Records: If the TED record is eligible to receive payment under the claims processing CLIN, then the TED record (with the exception of Type of Submission 'C' - complete cancellation to TED record data) shall be submitted by the Contractor to TMA using a Header Type Indicator of '6' or '9' (even if the TED record has already received payment under the claims processing CLIN).

G. 10.6.3. Cancelled TED Records: For a TED record submitted with a Type of Submission 'C' by the Contractor, the Contractor shall determine if the TED record is still eligible to receive payment under the claims processing CLIN. The following criteria shall be used to determine if a TED record is still eligible for payment:

G.10.6.3.1. A TED record cancelled for any of the following reasons is eligible to retain the claims processing fee previously paid and shall be submitted with Header Type Indicator '6' or '9':

- Cancellation was at Government direction.
- Government data error.

- Stale dated/voided checks.
- New initial TED record is required by the Government.
- Incorrect DEERS response.
- Check is returned in undeliverable mail.
- Beneficiary or provider requests stop payment due to non-receipt of check prior to stale date time period.
- Beneficiary or provider returns check because payment has been received from other health insurance carrier whose responsibility was previously unknown to contractor.
- Provider returns check because beneficiary has erroneously paid the provider and believes that the TRICARE benefit check is a duplicate payment.
- Claim processed in good faith by the contractor but later identified as an error due to additional information received or learned.
- Claim processed by multiple contractors resulting in duplicate processing.
- TQMC case resolutions resulting in an error.
- Program Integrity cases that are recouped retrospectively after investigation.
- Provider requested claims to be reissued to a new provider Tax Identifier.

G. 10.6.3.2. A TED record cancelled for any of the following reasons is not eligible to retain the claims processing fee previously paid and shall be submitted with Header Type Indicator '0' or '5':

- Cancellation where a new initial TED record is required to correct a contractor error.
- Cancellation due to contractor error or an inability to adjust.
- Cancellation of a claim that was not TMA's responsibility so should not have been paid.
- Any other cancellations for a reason not identified in paragraph G.10.6.3.1 above.

If the Contractor cannot determine the reason for the TED record cancellation, then the TED record submitted is not eligible to retain the claims processing fee previously paid. The cancellation of the cancelled TED record shall be submitted under Header Type Indicator '0' or '5'.

G.11. TEDS SUBMITTAL INSTRUCTIONS (UNDERWRITTEN AND NON-UNDERWRITTEN HEALTH CARE):

G.11.1. TEDS shall be submitted per TSM requirements which include separate groupings of underwritten and non-underwritten claims by CLIN for underwritten and the Automated Standard Application for Payment (ASAP) System ID for non-underwritten. Adjustments and cancellations may be included with initial submissions.

G.11.2. Voucher Transmission Requirements: Underwritten Batch/Vouchers shall be transmitted by 10 A.M. Eastern Time to be considered for that day's business. Non-underwritten Batch/Vouchers received after 10:00 AM Eastern Time shall be considered received the next business day for payment and check release authorization purposes. Batch/Vouchers must pass all TED header edits as specified in the TSM. If all header edits are not passed, the Batch/Voucher will be rejected and returned to the Contractor.

G.11.3. Voucher Integrity: Voucher header and detail amounts transmitted by the Contractor become "fixed" data elements in the finance and accounting system for purposes of control and integrity. Corrections or adjustments to reported (payment) amounts must be accomplished on separate voucher transmissions. Voucher submissions (non-underwritten payments) later determined to be underwritten benefits shall be corrected using the voucher process to reverse the submission and resubmitted under the batch process and vice versa (see TSM, Chapter 2, Section 1.1, paragraph 3.5.).

G.11.4. Payment Suspension and TED Processing During Partial Funding Shortages:

G.11.4.1. Some of the funding TMA receives may be restricted in use to a specific federal agency, military department and/or to a particular health care program. Funding for these special purpose programs may run out before funding for other TMA programs. Therefore, the Contractor shall have the ability to suspend claims payment and the associated submission of institutional TEDS records or noninstitutional TED line item(s) to TMA based on values contained in the following TED record fields:

- Service Branch Classification Code (Sponsor), SBCC - As specified in the TSM, Chapter 2, Section 2.8.
- Enrollment/Health Plan Code (E/HPC) - As specified in the TSM, Chapter 2, Section 2.5.
- Special Processing Code (SP) - As specified in the TSM,Chapter 2, Section 2.8.
- Health Care Delivery Program Coverage Code - As specified in the TSM, Chapter 2, Addendum M.

G.11.4.2. The suspension of claims payment and TED records may be based on a single value (e.g., SBCC=A) or a combination of values (e.g., SBCC=A & E/HPC=SR). Suspension of TED records (institutional) or TED line items (non-institutional) containing specific values shall be implemented by the Contractor within five workdays after receiving notification from the Contracting Officer. On the sixth workday, TMA/CRM will implement immediate payment offset against Contractor invoices of any amounts paid by the Contractor from their non- underwritten bank account(s) for institutional TED records or non-institutional TED line items containing suspended value(s). The Contractor shall not, without prior Contracting Officer approval, initiate payment offset against any provider or beneficiary for payments made against suspended transactions and offset by TMA/CRM on Contractor invoices.

G.11.4.3. For all suspended transactions, the Contractor shall hold the claim information until receiving instructions from the Contracting Officer to do otherwise. The Contractor shall not reject the claims or return any information to the providers or beneficiaries unless instructed by the Contracting Officer. Once the Contracting Officer lifts the TED data submission restriction, the Contractor may submit all withheld TED data on the next appropriate (batch/voucher) data submission. TMA/CRM will reimburse the Contractor (without interest) for any invoice payment offsets done for TED suspended transaction that have not been recouped by the Contractor.

G.11.5. Federal Fiscal Year-end Processing:

G.11.5.1. All TEDS data must be received no later than 10:00 AM EDT, (8:00 AM MDT; 7:00 AM PDT) on September 28. Any Batch/Voucher received after 10:00 AM EDT will be rejected by TMA and must be resubmitted by the Contractor using next fiscal year Batch/Voucher CLIN/ASAP Account Numbers. The Contractor should not submit batch/vouchers with dates of September 29 and September 30. Any payment processed after September 28th, must use the next fiscal year Batch/Voucher CLIN/ASAP Account Numbers and must utilize the new fiscal year check stock, as applicable. The Contractor shall not submit Batch/Vouchers to TMA between September 28, 10:00 AM Eastern Time or before October 1, 12:01 AM Eastern Time. Transmission Files (TD Files) sent on September 28th cannot exceed 300,000 records.

G.11.5.2. All payments not included in the Contractor's final fiscal year data submission on September 28 must have a Batch/Voucher Date on or after October 1. Contractors will be able to test their new fiscal year's transactions in benchmark starting September 1. Like production, benchmark data must be received at TMA by 10AM EDT on September 28. After 10 AM EDT on September 28 until October 1, 12:01 AM Eastern Time no benchmark data can be transmitted to TMA.

G.12. UNDERWRITTEN HEALTH CARE (COST REIMBURSEMENT) - TEDS

G.12.1. Underwritten claims are reimbursed upon all TED records within a TED header clearing edits and each record clearing validity edits. TMA/CRM will disburse payment to the Contractor based on the automated TED report. If the TED records are credits, which will result in a payment to the Government, collection will be made based on the same terms as payment for that respective CLIN. Credits must be applied back to the same sub-CLIN from which it came. Credits do not have to pass all TRICARE System Manual edits, TMA/CRM will collect all underwritten credits back within seven calendar days of receipt.

G.12.2. Underwritten Under Payment (See TOM Chapter 11): When the Contractor makes an additional payment due to a prior underpayment, these payments shall be reported as an adjustment to the original TED record, but in the current fiscal year and the Contractor shall use the Begin Date of Care to determine the appropriate CLIN/ASAP ID. This would normally be the same CLIN (first six positions of CLIN/ASAP ID) used to make the original payment.

G.12.3. TED Credit Adjustment Procedures: When the Contractor submits a credit TED Record under an active underwritten CLIN, the contractor shall cite the current fiscal year underwritten CLIN/ASAP Account Number associated with the CLIN from which the Contractor originally submitted it under.

G.12.4. TED Underwritten Data Submissions for Inactive CLINs: TMA will administratively set an underwritten CLIN to an 'inactive' status when the health care cost audit process is initiated, so TED records accepted under the CLIN at that time are segregated for audit. TMA will notify the contractor at least 30 days before an underwritten CLIN is set to an 'inactive' status. When the CLIN is set to an 'inactive' status, the CLIN is closed for all TED processing. After CLIN closure, the contractor is required to submit TED records previously accepted under the closed CLIN (the audit population) using the Batch TED data submission process under G.12.4.2. below.

G12.4.1 At the same time an underwritten CLIN is inactivated, the Contracting Officer will administratively establish a new underwritten CLIN for continued reimbursement of initial and resubmission TED records for those actions occurring after the health care audit process is initiated (i.e., after the initial CLIN is closed). This CLIN will remain active as long as the Contractor submits TED records for care rendered with a begin date of care during the option period.

- For all Batch/Voucher submissions that are in a resubmission status (Batch/Voucher Resubmission Number greater than 00, TSM Chapter 2, Section 2.3) at the time the CLIN is set to inactive, the contractor shall replace the existing CLIN type Batch/Voucher CLIN/ASAP Account Number in the header with the new CLIN type Batch/Voucher CLIN/ASAP Account Number (TSM Chapter 2, Section 1.1, paragraph 6.1) assigned to them by TMA, CRM. The contractor shall continue to resubmit the Batch/Voucher until clearing all TED edits. The resubmission number shall not change at the time of conversion (TSM Chapter 2, Section 2.3).

G.12.4.2 Upon CLIN closeout, corrections/overpayments toTED records previously accepted under the inactive CLIN shall be submitted to TMA using a Batch type (all zero's) Batch/Voucher CLIN/ASAP Account Number (TSM Chapter 2. Section 1.1, paragraph 6.1)

G.12.5. Fiscal Year Start-up: The October 1st TED and subsequent data submissions must cite the new fiscal year "Batch/Voucher CLIN/ASAP Account Number" assigned by TMA/CRM to report all new fiscal year TED data. Any previously unreported TED data citing the prior fiscal years "Batch/Voucher CLIN/ASAP Account Numbers" will not be accepted. New "Batch/Voucher CLIN/ASAP Account Numbers" used for Underwritten healthcare costs shall reflect as follows: the first six positions equal to the SLIN (zero fill positions 5 & 6 if not used), position 7 shall equal the federal fiscal year and position 8 shall equal the Contractor's region (N = North, S = South & W = West).

G.12.6. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the Contractor may submit electronic vouchers (i.e. SF1034) outside of the TED system to the Contracting Officer for underwritten healthcare costs. The invoice shall identify the underwritten health care paid and the number of claims processed by CLIN. This may be submitted daily or grouped by no more than five days of claims. These payments will be treated as an interim payment and will be a credit to the amount due as determined by the TED Record processing system when it is operating again.

G.13. NON-UNDERWRITTEN HEALTH CARE (Pass Through) - TEDS

G.13.1. The Contractor acts as a Fiscal Intermediary for the Government to distribute, or pass-through, Government funds for certain non- underwritten health care benefits. These are not costs to the Contractor and are not reimbursed by the Government, so the Contractor shall not collect or hold non-underwritten benefit funds before dissemination to the beneficiary or provider and the Contractor shall immediately return any collections to the Government.

G.13.1.1. Non-underwritten benefit payments by the Contractor on behalf of the Government will be facilitated by allowing the Contractor (through the Contractor's financial institution) to draw money from the designated Federal Reserve Bank (FRB). These draws may only be done for benefit payments that have previously been submitted on TEDs or as a non-TED, non- underwritten voucher and approved for release by TMA/CRM and are clearing the Contractor's financial institution on the day the draw is being accomplished. Advance payments are not allowed. No bank fees or other bank charges shall be paid from this account and no money should be drawn from the FRB for these charges.

G.13.1.2. All payments for non- underwritten claims processed by the Contractor must be approved by the TMA/CRM Budget Office before the Contractor may make payments to the beneficiary or provider. Unapproved draws and payments by the Contractor will be immediately collected and subject the Contractor to interest and penalties.

G.13.2. Establishment of Non-Underwritten Bank Accounts:

G.13.2.1. The Department of Treasury's Automated Standard Application for Payment System (ASAP), along with FEDWIRE, provide a mechanism for disbursement of Government funds for health care services received by TRICARE beneficiaries that are not underwritten by the Contractor. After authorization by TMA/CRM, these systems allow the Contractor to draw cash directly from the FRB to cover payments as they clear the Contractor's bank account. ASAP is used by the Treasury, the FRB and TMA/CRM to verify the authorization to make draws and to track transactions made by the Contractor's bank. FEDWIRE is used by the Contractor's bank to actually draw funds from the FRB.

G.13.2.2. The Contractor shall establish bank account(s) for non-underwriting transactions with a commercial bank that has FEDWIRE capability following Treasury requirements. The Contractor shall submit bank information to TMA/CRM not later than 60 calendar days prior to the beginning of processing claims on a new account. The information shall include:

- Name of Bank
- Overnight mail address
- American Banking Association (ABA) routing number

- Taxpayer Identification Number (TIN) (must be the same TIN used for payment)
- Contractor's bank account number (if separate checking and deposit accounts are used, both need to be provided)
- Individual point of contact at the bank and an alternate, including their phone numbers, fax numbers and e-mail addresses
- Individual point of contact at the Contractor and an alternate, including their phone numbers, fax numbers and e-mail addresses

G.13.2.3. TMA/CRM will establish the bank account(s) on ASAP with the Treasury Department. TMA/CRM will notify the bank and the Contractor once the bank account(s) have been established and provide codes or other information necessary for the bank to make draws against the FRB using FEDWIRE. Currently, ASAP has a requirement to identify a total dollar amount that may be drawn on the FRB. This dollar limit, established by TMA/CRM, only represents an administrative ceiling at the FRB, and does not constitute any authority to draw funds. Accounts will also have daily limits for the amount that can be drawn. The Contractor will be notified of these limits by TMA/CRM. TMA/CRM will be able to increase these limits as needed.

G.13.3. Authorization to Release Non-Underwritten Payments:

G.13.3.1. TED data submissions for non-underwritten benefit payments shall be grouped into TED Vouchers by the "Batch/Voucher CLIN/ASAP Account Number" field (defined in TSM, Chapter 2, Section 2.2). The Contractor shall not release non- underwritten benefit payments without prior authorization from the TMA/CRM Budget Office. Authorization from TMA/CRM to release payments will be sent to the Contractor via fax or e-mail no later than 5:00 PM Eastern Time the day of receipt. Authorization will specify contract number, ASAP Account ID#, initial transmission received date, and total dollar amount of funds that may be released based on information contained in the Batch/Voucher header. Approval for funds release will be given provided the following criteria are met:

- Voucher submissions must pass all header edits as specified in TSM, Chapter 2, Section 2.3.
- TMA/CRM Budget Officer has confirmed that funding is available to cover payments.

G.13.3.2. Benefit payments shall be released/mailed no later than two workdays after TMA/CRM has approved the release of payments.

G.13.3.3. Authorization to release payments does not constitute TMA's acceptance that all payments are valid and/or correct. Detailed records will be audited for financial compliance. All transactions in these bank accounts must be valid and justified. Any unreported/unauthorized disbursements identified by TMA will be subject to immediate payment offset against any payments being made to the Contractor. All disputed amounts will remain in the possession of the Government until no longer in dispute.

G.13.3.4. Upon notification by the Contracting Officer that the TED Record processing system is not operating normally, the Contractor will send an email or fax with a listing of specific vouchers to TMA/CRM to request release of payments. This may be done daily. TMA/CRM will return to the Contractor a signed release so the Contractor can pay the providers and beneficiaries without delay. The Contractor must not release payments until this approval is received. Upon notification by the Contracting Officer that the TED Record processing system is operating again, this process can be discontinued and the Contractor shall have 30 days to clear all vouchers where payments have been released thru the TED header edits (as specified in the TRICARE Systems Manual, Chapter 2). Failure to clear all header edits for any vouchers where the Contractor was authorized under this contingency process to release payments shall result in the Government collecting back the rejected voucher header totals via payment offset. When the vouchers clear the header edits, the monies collected via payment offset shall be refunded to the Contractor (without interest or penalty). The Contractor requests will include the following Header information for each voucher (See TRICARE Systems Manual, Chapter 2, Section 2.2):

ELN Element Name
0-001 Header Type Indicator
0-005 Contract Identifier
0-010 Contract Number
0-015 Batch/Voucher Identifier
0-020 Batch/Voucher Number
0-025 Batch/Voucher ASAP Account Number
0-030 Batch/Voucher Date YYYYDDD
0-035 Batch/Voucher Sequence Number
0-040 Batch/Voucher Resubmission Number
0-045 Total Number of Records
0-050 Total Amount Paid

G.13.4. Draws on the Federal Reserve:

G.13.4.1. The Contractor shall ensure that cash draw downs do not exceed the payments authorized, as they clear the bank on a given day, less deposits. The Contractor shall ensure that any excess draws are immediately returned to the FRB. Interest and a penalty will be charged beginning the day after the overdraw and will continue until the overdraw amount is returned. Interest will accrue daily and is based on the Treasury Current Value of Funds Rate. The penalty will accrue daily and is based on the penalty rates in the Code of Federal Regulations, Title 31, Volume 1, PART 5, Subpart B Sec.5.5. TMA/CRM may initiate immediate payment offset against any payments to the Contractor involved for the interest, penalties and/or the overdrawn amount.

G.13.4.2. Contractors with more than one bank account shall ensure transactions are properly accounted for to prevent the commingling of funds. Failure to properly associate transactions with the correct bank account could result in the over-execution of TMA/CRM budget authority. Transfers of funds between bank accounts are strictly prohibited except for correcting deposits that are in the wrong account. Any transactions reported under one bank account and erroneously charged against a different bank account shall be reported immediately to TMA/CRM when identified. TMA/CRM will instruct the Contractor as to what action to take.

G.13.4.3. The total amount of a cash draw down on the FRB is based on the daily total of benefit payments presented to the bank for payment. If estimates are needed due to timing of reports from check clearinghouses or the FRB, the draws shall be adjusted the next business day.

G.13.4.4. Computation of the amount of the draw must include any deposits of funds into the account. These deposits will reduce the amount of cash needed for the draw down on the day of the deposit.

G.13.5. Financial Editing of Detail Claims Data for Non-Underwritten Claims: The TED system allows for the categorization of claim errors based on the type or classification error failed during the edit process. TMA/CRM will use the edits specified in the TRICARE Systems Manual, Chapter 2, Section 8.1, Financial Edits, to determine the propriety of payments. TED records that fail the Financial Edits specified in the TRICARE Systems Manual, Chapter 2, Section 8.1 will be "flagged" by TMA/CRM as inadequate payment information. The Contractor shall correct the claims flagged by TMA/CRM within 90 calendar days. If not corrected in 90 days, TMA/CRM will send a demand letter requiring resolution or reimbursement for all claims identified through TEDs as edit failures. The Contractor shall respond within 30 calendar days as to why the claim(s) in question cannot be corrected. If resolution cannot be reached between TMA/CRM and the Contractor, the total amount of improper payments still in dispute will be collected by TMA/CRM. The Contractor shall take no recourse against TRICARE beneficiaries or providers under the situations described in this paragraph without prior TMA approval.

G.13.6. Fiscal Year Start-up of Non- Underwritten ASAP Accounts:

G.13.6.1. The Contractor shall establish a separate bank account for each new Government fiscal year following the procedures specified in G.13.2. "Establishment of Non-Underwritten Bank Accounts". All payments issued for benefit payments and all refunds received shall be processed against the new account effective the first day of the new fiscal year. The Contractor shall also transfer all recoupment installment payments to the new account from the previous year's account.

G.13.6.2. Cash draw downs against the prior fiscal year's bank account may continue, if required, until all payments from the prior year have either cleared or have been canceled, but no longer than the end of February of the following year or five months after the last payments have been cut on an account (in the case of a contract closeout).

G.13.6.3. Bank accounts shall be closed no later than the end of February, following the fiscal year end, or one month after the last payment on an account has been made or voided. Final bank account reconciliation shall be made within 30 calendar days following the last authorized transactions. All transactions that were not previously approved by TMA/CRM shall be explained with supporting documentation on the final bank reconciliation report (Section F.5.1.3.). TMA/CRM reserves the right to not accept these transactions.

G.13.6.4. Any outstanding balance in the account shall be reimbursed to TMA no later than the required submission date of the final bank account reconciliation. This balance may be subject to interest if it includes overdrawn amounts that were required to be submitted at an earlier date.

G.13.7. Voided or Stale-dated Payments

G.13.7.1. For payments that are voided or stale-dated that are over $10, a credit voucher through TEDs must be processed in accordance with the standards detailed in TSM Chapter 1, Section 3. If the check was issued as a manual voucher, the credit should be submitted as a similar manual voucher. The only exception to issuing a credit voucher would be stale-dates under $10.00.

G.13.7.2. For voided/stale-dated payments of $10.00 or less, the Contractor may elect either to:

- Affect a credit voucher for the check using automated means, or
- Instead of making a voucher transaction, a memorandum record shall be prepared and included on a listing of transactions as submitted monthly in the Non- Underwritten Funds Bank Account Reconciliation Report.

G.13.7.3. Replacement Payments:

G.13.7.3.1 Reissuance of payments will be made against the current fiscal year bank account.

G.13.7.3.2. Replacement payments may be issued upon request of the payee or authorized representative. If the check is not returned by the payee, the payee must provide a statement describing the loss or destruction of the check. Before a replacement check is issued, a stop payment order for the original check must have been issued and accepted by the bank.

G.13.7.3.3. If the claim history is not available to the Contractor, the Contractor shall submit a request for approval of check release to TMA/CRM within 10 workdays from the request by payee. Supporting documentation shall include the original check, the sponsor's SSN, a copy of the EOB, (if available) or other documentation showing the computation and payment of the original check, and the check or copy or statement as described in G.13.7.3.2. above.

G.13.7.3.4. The Contractor shall report the reissuance using the same procedure as was used to void/staledate the original.

G.13.7.3.4.1. If no credit voucher was made in voiding/stale-dating of the check, no credit voucher is required for the reissue (i.e. if the Contractor gets a returned check and immediately reissues from the same bank account, no TED or other voucher needs to be done). If the reissuance involves a check from a prior year, a TED or other voucher will need to be done to report the reissuance from the current year.

G.13.7.3.4.2. If the amount of the stale-dated check to be reissued is $10.00 or less, the Contractor shall use the same procedure in the reissuance as was used for the stale-dating. If no credit voucher was made in the stale-dating of the check, no credit voucher is required for the reissue. The Contractor shall reissue the payment and include the amount in the Non- Underwritten Funds Bank Account Reconciliation Report.

G.13.7.3.5. Reissuance of Payments When Original Payee is Deceased: Payments issued by the Contractor shall be made payable to the legal representative of the estate of the person concerned with an additional line stating "For the estate of _____." Payments shall not be payable to the "estate of" a decedent, nor to a deceased person. Payments shall be to the named payee or mailed to the payee's address of record.

G.13.8. Non-Underwritten Under Payments: When the Contractor makes an additional payment due to a prior underpayment, these payments shall be reported as an adjustment to the original TED record, but in the current fiscal year and current CLIN/ASAP ID regardless of the fiscal year or CLIN/ASAP ID of the original payment.

G.13.9. Non-Underwritten Overpayments: When reporting collections the Contractor makes (whether cash or offset), the collection shall be accomplished as a separate credit transaction as an adjustment to the original TED record. Identified debts shall be reported on the Accounts Receivable Report in accordance with Section F.5.1.3.

G.14. INVOICE AND PAYMENT NON-UNDERWRITTEN - NON-TEDS

The Contractor shall group and electronically process each type of Non-TED voucher by each non-underwritten cost category identified below as a pass-through payment.

G.14.1. Capital and Direct Medical Education Costs (CAP/DME): Are paid by the Contractor from the non-underwritten bank account to hospitals requesting reimbursement under the TRICARE/CHAMPUS DRG-Based Payment System (excludes children's hospitals) (see TRM Chapter 6, Section 8).

G.14.1.1. The Contractor shall submit a monthly CAP/DME voucher in a .csv format to TMA/CRM no later than the 20th calendar day of the month following receipt of the hospital's request for payment. Supporting documentation, including copies of the hospital's claim and the payment calculation, shall be submitted electronically using approved formats specified in TOM Chapter 2. Within two calendar days after receiving disbursement clearance from TMA/CRM, the Contractor shall complete the process by making payment to the hospital.

G.14.1.2. If the Contractor makes an underpayment, the Contractor shall determine the amount and pay any amount due to the hospital with the next group of payments made. If the Contractor overpays a hospital, the Contractor shall recoup this amount and document as follows:

a. Offset funds shall be included as credits on the monthly CAP/DME voucher for the month the credits were processed.

b. Collections shall be included as credits indicating the month the collection was deposited (normally the prior month).

c. Debts established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report.

G.14.1.3. Federal Fiscal Year-end Processing of Non-TED Vouchers: September CAP/DME vouchers that are submitted in the month of October shall utilize the October new fiscal year check stock.

G.14.2. Bonus Payments (HPSA/PSA): Bonus payments are an addition to the amount normally paid under the allowable charge methodology in order to provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. On a quarterly basis, the Contractor shall submit the voucher electronically as a pass-through payment. Supporting documentation including lists of doctors, their addresses, and the calculation of the payment, shall also be sent electronically based on approved formats as specified in the TOM, Chapter 2. The Contractor shall process and make payment within 2 business days after receipt of clearance from TMA/CRM.

G.14.2.1. Vouchers shall contain the following:

a. Format for Vouchers
- Period Covered (Quarter
- Physician Name
- Physician Address
- Physician Provider Number
- Amount Paid/Collected for Bonus Total Bonus Paid [5 and/or 10 percent of the above bullet]
- Total of all Bonuses being paid

b. Sort for Vouchers
- By Contract
- By Automated Standard Application for Payment System (ASAP) ID (Fiscal Year) of Bank Account
- By Type (e.g., standard or active duty)
- By Coverage (Prime, Extra, Standard)
- By State
- By Physician
- By Physician Number
- By Specialty
- By Address & Zip
- By Participating & Non-Participating
- By Contracted (Network) and Not Contracted (Non-network)
- By Modifier ("QB", "QU" or "AR")

G.14.2.2. Federal Fiscal Year-end Processing: September HPSA vouchers that are submitted in the month of October shall utilize the October new fiscal year check stock.

G.14.3. Demonstrations: These are trial programs and they may vary in many ways from TRICARE benefits. TEDs will be used if possible but if the data associated with demonstrations is incompatible with TED data formats, the Contractor shall submit a separate voucher to TMA/CRM no more frequently than monthly to obtain clearance to make non- underwritten bank account transactions.

G.14.4. Other Payments: Other adjustments are rare situations where a payment needs to be made but does not fall into routine processing such as TEDs, etc. For example, these payments may be the result of a very old case or legal settlements that don't apply to a given individual. These must be submitted to the Contracting Officer and to TMA/CRM with supporting documentation explaining the issues that don't allow a TED record along with the claim, computation, and other applicable documents. After release approval by TMA/CRM, the Contractor shall make payment within 2 working days. The Contractor shall report these payments on the Bank Reconciliation Report under TMA approved manual transactions.

G.15. TRICARE RESERVE SELECT PREMIUMS:

The Contractor shall establish separate non-interest bearing account for the collection and disbursement of TRS premiums. The Contractor shall make daily deposits of premium collections to the established account. The Contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified Government account as directed by TMA/CRM Finance and Accounting Office. The Government will provide the Contractor with information for this Government account. The Contractor shall notify the TMA/CRM by e-mail within one business day of the deposit specifying the date and amount of the deposit. The Contractor shall submit a monthly TRS report with premium activity supporting the wire transfer of dollars, including premium billings, collections, and enrollments (Section F).

G.16. RESERVED

H.1 CONTRACTOR FINANCIAL UNDERWRITING OF HEALTH CARE COSTS

H.1.1. The Managed Care Support (MCS) Contractor shall underwrite the cost of civilian health care services (also referred to as "purchased care" which is defined as care rendered outside the Direct Care System) provided to all CHAMPUS-eligible beneficiaries who are enrolled in the contract region, or for non-enrollees who reside in the contract region, except for the following non-underwritten categories:

-Outpatient retail and mail order pharmacy services (on separate contract)
-Active Duty Service Members including TRICARE Prime Remote for Active Duty Service Members (Active Duty Family Members are underwritten)
-Continued Health Care Benefits Program (CHCBP)
-Foreign/OCONUS beneficiaries and CONUS-based beneficiaries who receive care OCONUS (on separate contract)
-Medicare dual-eligible TRICARE CHAMPUS beneficiaries (on separate contract)
-Cancer prevention and treatment Clinical Trials demonstration (for those beneficiaries enrolled in the demonstration on or before March 31, 2008)
-State of Alaska (care for beneficiaries who are enrolled in the state of Alaska and care for non-enrollees who reside in the state of Alaska)
-In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration
-Bonus Payments in Medically Underserved Areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]
-Capital and Direct Medical Education (Cap/DME)
-TRICARE Reserve Select
-Custodial Care Transitional Program (CCTP)
-Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)
-Residual Claims (date of service prior to the start of health care delivery under the contract)
-Autism Services Demonstration

*CHAMPUS-eligible beneficiaries are defined as those beneficiaries that meet the requirements in Title 10, United States Code, Chapter 55.

H.1.2. In this contract, these underwritten beneficiaries may be referred to as "underwritten beneficiaries" or "non-TRICARE/Medicare dual-eligible CHAMPUS eligible beneficiaries". In this contract, the health care costs the Contractor underwrites may be referred to as "health care cost" or "underwritten health care cost".

H.1.3. Other supplemental details regarding underwritten health care follow:

H.1.3.1. Beneficiaries may enroll in TRICARE Prime with an MTF Primary Care Manager (PCM). Even though they may have an MTF PCM, Prime enrolled non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries' costs outside of the MHS direct care system are underwritten by the Contractor, except for ADSMs.

H.1.3.2. The health care costs for beneficiaries enrolled in Prime are underwritten by the Contractor in whose region the beneficiary is enrolled, regardless of the address or location of the beneficiary.

H.1.3.3. Enrollment fees collected by the Contractor are not considered health care costs. These fees are considered as a part of the PMPM price of the contract and are retained by the Contractor.

H.1.3.4. The costs of medical management activities, such as case management, disease management and utilization management, are not considered underwritten health care costs. Cost under separate Clinical Support Agreement orders, if issued, are not considered underwritten health care costs.

H.1.3.5. Capitation arrangements are prohibited.

H.1.4. Underwritten health care is cost-reimbursable. These costs are reimbursed with obligated funds that are dispersed under this contract. The associated underwritten fixed fee in Section B of the contract is considered the underwriting fee, or underwriting premium.

H.1.4.1. For administrative purposes, underwritten health care cost is broken down into two main Contractor underwriting risk categories:

H.1.4.1.1. Contractor Network Prime Enrollees: These are TRICARE Prime enrollees with network PCMs. The Contractor underwrites TRICARE healthcare services provided to Prime enrollees with network PCMs (exclusive of TRICARE Prime Remote [TPR] beneficiaries).

H.1.4.1.2. Non-Prime Beneficiaries and MTF Prime Enrollees: This category includes health care services provided to all other underwritten beneficiaries, including:

-Non-Prime enrolled, non-TRICARE/Medicare dual-eligible beneficiaries
-TRICARE Standard,
- TRICARE Extra
-TPR-ADFM Enrollees
- MTF Prime Enrollees (Prime Enrollees with MTF PCMs)

H.2. HEALTH CARE UNDERWRITING INCENTIVES

H.2.1. Introduction and Administration: This section addresses the administration of the positive and negative incentives that are part of the underwriting mechanism of the contract. The Contractor may earn a performance incentive by either exceeding a minimum standard, or for performance above a fully satisfactory level in areas that reduce health care cost and are measurable as defined in this section for each respective option period. The financial administration of the incentives' assessment for a given option period will be conducted after completion of the option period. When performance exceeds the standard, or exceeds the fully satisfactory level specified in the paragraphs below, the Government administratively obligates funding equal to, or greater than, the stated incentive amount into the applicable Performance Incentive Funding contract line item in Section B. After the Government has completed measurement and any administrative funding action(s), and the Contracting Officer notifies the Contractor of the incentive earned (if any), the Contractor may invoice and receive payment for the amount authorized by the Contracting Officer. The Government will obligate funds at any time on the performance incentive funding contract line item as the Contracting Officer determines necessary to ensure sufficient funds are available to pay the Contractor any earned incentive amount. If the Contractor fails to meet the fully satisfactory levels described below and earns a negative incentive, the funded amount on the performance incentive contract line item may be netted, or the payments from the performance incentive contract line item are offset by the negative incentive amount. If the offset amount is greater than any earned incentive (if any), or the Contractor only earns a negative incentive, the Contracting Officer will deduct that amount from the next payment from any administrative contract line item of this contract.

H.2.1.2. For purposes of administering underwriting incentives, the underwritten population will be divided into two separate underwriting risk groups, which are identified as two separate CLINs in Section B:
-Contractor Network Prime Enrollees
-Non-Prime Beneficiaries and MTF Prime Enrollees

H.2.2. Dollar Limits of Underwriting Incentives: There is no ceiling limit on the net positive incentives that may be earned in a given option period. There is a maximum limit on the net negative incentives that may be assessed for the three underwriting incentives combined (these incentives are described in Section H.2.3). This amount is equal to the underwriting fixed fee amount for each option period identified in Section B, plus the amount identified below for each option period and underwriting category. This means the maximum negative net incentive will exceed the underwriting fixed fee paid to the Contractor by the amounts listed below.

H.2.2.1. WEST REGION Network Prime enrollees:
--OP 1: $26,202,118
--OP 2: $25,587,188
--OP 3: $31,375,085
--OP 4: $34,449,571
--OP 5: $37,754,351

H.2.2.2. WEST REGION MTF Prime enrollees and non-Prime beneficiaries:
--OP 1: $19,761,374
--OP 2: $20,873,045
--OP 3: $22,238,704
--OP 4: $23,752,356
--OP 5: $25,373,703

H.2.2.3. The negative incentive dollar limit identified in H.2.2 above are independent of the results of the annual healthcare cost audits for overpayments to providers (i.e., the limits on the underwriting incentives do not limit the Contractor's financial liability for claims overpayments as determined by audit). The assessment, including recovery from the Contractor, of any negative incentive dollar amount is conducted separately from the underwriting fixed-fee payments for each option period.

H.2.3. Incentives. The administration of the Network Discount Incentive, the Network Usage Incentive, and the National Cost Trend Incentive described herein is assessed before any cost audit that determines allowable and unallowable health care costs. The Contractor will be assessed the following positive and negative incentives, based on performance:

H.2.3.1. Network Discount Incentive. The purpose of this incentive is to encourage Contractors to proactively negotiate discounts with network providers and thereby reduce underwritten health care costs. The incentive will be calculated separately for two different categories of beneficiaries. The first category includes all Contractor Prime network enrollees and the second category consists of all MTF Prime enrollees and non-enrolled beneficiaries.

H.2.3.1.1. This incentive will be calculated as ten percent (10%) of the average value of discounts from TRICARE allowable charges for care provided by civilian network providers to Contractor Prime network enrollees, and MTF Prime enrollees and non-enrolled beneficiaries that exceed a minimum average discount level of (b) (4). (The incentive will be calculated once for care provided to Contractor Prime network enrollees and once again for care provided to MTF Prime enrollees and non-enrollees.) For example, if the calculated total value of discounts obtained in a given option period is $60 million and this represents a (b) (4) average discount, the incentive amount would be ten percent (10%) of the amount above the (b) (4) minimum average discount level. Since the (b) (4) (b) (4) in this case represents (b) (4) the average value of discounts obtained above the minimum threshold equals (b) (4) The incentive payment would be, therefore, (b) (4) If the estimated network discounts obtained for the option period do not exceed the (b) (4) level average value of discounts, no incentive payment will be made.

H.2.3.1.1.1. The TED record must reflect the actual dollar amount of network discount, excluding other health insurance (OHI) claims. The dollar amount of the network discount is the difference between the network provider's negotiated rate and what TRICARE reimbursement methodology would have allowed in the absence of the negotiated discount rate. See the TRICARE Systems Manual, Chapter 2 for the TED record requirements for correctly coding the provider network discount.

H.2.3.1.1.2. The network discount incentive will be calculated after the end of the option period based on TED records accepted during that option period (excluding OHI claims) for each of the above two categories of beneficiaries for care provided by Contractor network providers. The percent of discounts will be determined by dividing the total value of discounts reported by the total allowable costs, specifically: the total amount of network discounts achieved during the period will be the numerator; the denominator will be the sum of the amounts that were allowed prior to applying the network discount. The total value of discounts will be the sum of all dollar amounts reported on TED records in the field "Amount Network Provider Discount." For care provided to Contractor network enrollees by Contractor network providers (excluding OHI claims), the total allowable cost will be the sum of all dollar amounts reported on TED records for all amount allowed fields and all amount of network provider discount fields.

H.2.3.2. Network Usage Incentive. The purpose of this incentive is to promote a higher percent of usage of network providers by all prime enrollees, thereby reducing the enrollees' out-of-pocket costs and potentially reducing underwritten health care costs.

H.2.3.2.1. Network Usage by Prime Enrollees (Combined MTF enrollees and Contractor network enrollees). This incentive can only result in either no payment or a negative incentive. It will be measured based on the number of civilian network provider claims for Prime Enrollees compared with the total number of civilian claims for these beneficiaries, after excluding claims with other health insurance (OHI), Prime Point-of-Service (POS) claims, claims for care provided out-of-region, TRICARE Prime Remote, and claims for emergency care. The exclusion applies if any line item on the claim meets the exclusion criteria. If the percentage of network versus total claims meets or exceeds the minimum standard for a given month, no negative incentive will be applied. If the network percentage falls below that standard, a negative incentive will be assessed on a per-claim basis for the calculated number of non-network claims that fall below the standard. This will be done according to a series of percentage corridors, with larger negative incentives applied for successively larger discrepancies between the standard and the actual level of performance.

West Region:	Option Period 2	73%
	Option Period 3	74%
	Option Period 4	75%
	Option Period 5	76%

H.2.3.2.2. No incentive will be applied for Option Period 1. Beginning with Option Period 2 for each month that the minimum claims percentage is not met, a negative incentive shall apply. The network usage incentive will be calculated after the end of the option period based on TED records accepted during each month of the option period. The Government will apply an incentive for every claim that falls below the minimum standard. The amount assessed per claim is based on the percentage below the standard as follows:

West Region, Option Period Two:
If less than 73% and more than or equal to 70% = $7.00 per claim
If less than 70% and more than or equal to 68% = $14.00 per claim
If less than 68% and more than or equal to 67% = $21.00 per claim
If less than 67% = $28.00 per claim

West Region, Option Period Three:
If less than 74% and more than or equal to 71% = $7.00 per claim
If less than 71% and more than or equal to 69%= $14.00 per claim
If less than 69% and more than or equal to 68% = $21.00 per claim
If less than 68% = $28.00 per claim

West Region, Option Period Four:
If less than 75% and more than or equal to 72% = $7.00 per claim
If less than 72% and more than or equal to 70% = $14.00 per claim
If less than 70% and more than or equal to 69% = $21.00 per claim
If less than 69% = $28.00 per claim

West Region, Option Period Five:
If less than 76% and more than or equal to 73% = $7.00 per claim
If less than 73% and more than or equal to 71% = $14.00 per claim
If less than 71% and more than or equal to 70% = $21.00 per claim
If less than 70% = $28.00 per claim

H.2.3.2.3. For example, in month 2 of Option Period 2, West Region, if the actual percent of Prime enrollee claims with a network provider is 69%, then a negative performance incentive equal to 4% of the claims will be assessed (4% represents the difference between the actual number of claims for care provided by a network provider and the standard). If 4% equates to 200 claims not meeting the standard, the performance incentive assessment for that month will be -$2,800.00, or 200 claims times $14.00. In determining the performance incentive, the applicable amount will be determined based on the Contractor's actual performance. For instance, in the example above, the Contractor's actual performance was 69%, so the performance incentive will equal $14.00 for every claim falling below the minimum performance standard of 73%. In other words, the highest per claim amount will be applied to all claims failing the standard. The Government will not stratify the performance incentive based on the variable per claim amounts.

H.2.3.2.4. The percentage standards above, and the claims volumes used to calculate performance against those standards, will reflect claims for both MTF Prime enrollees and Contractor Network Prime enrollees combined. In the event a negative incentive amount is assessed, the resulting dollar amount will then be administratively allocated to MTF Prime enrollees and Contractor Network Prime enrollees based on their respective percentage shares of the overall network plus non-network claims volume used in the incentive measurement (after the exclusions of OHI claims, POS claims, etc.). As an example of this allocation approach, if the composite network usage standard were not met and a $1 million negative incentive result were assessed, and if MTF Prime enrollees comprised 70% of the network plus non-network claims considered in this incentive measurement and Contractor Network Prime enrollees comprised 30% of the claims, then $700,000 of the incentive result would be allocated to MTF Prime enrollees and $300,000 would be allocated to Contractor Network Prime enrollees.

H.2.3.3. National Cost Trend Incentive. The purpose of this incentive is to motivate cost-control efforts by the Contractor for Contractor Network Prime enrollees, by comparing the observed annual trend in the underwritten costs of Contractor Network Prime enrollees in the contract region as a whole to an external national standard, a level of performance the Contractor is expected to achieve. The observed trend will be adjusted for changes in the percentage of care provided in the Contractor network versus at Military Treatment Facilities (MTFs), for changes in enrollment levels, and for change orders affecting underwritten health care costs. This incentive calculation is described below, and a detailed hypothetical example is presented in Attachment J-6, Hypothetical Example of the External Trend Incentive Calculation.

H.2.3.3.1. For this incentive, the national external trend used as a standard of comparison will be a sub-set of the National Health Expenditures (NHE) trends reported annually by the Office of the Actuary, Centers for Medicare and

Medicaid Services (CMS). Specifically, the national external trend standard will be the portion of the NHE trend for Personal Health Care Costs Per Capita represented by Hospital Care, Professional Services (for Physician and Clinical Services and for Other Professional Services only), and Durable Medical Equipment. Other categories of Personal Health Care Costs are excluded from the national external trend standard either because they are not representative of the underwritten care under this contract (such as dental care and most prescription drugs) or because they are disproportionately represented in the NHE projections relative to the underwritten costs of this contract (such as home health care and nursing home care). The per capita NHE national trend data is used as the basis of the external national trend standard for the following reasons:

a) the NHE data reflect the broad national health care sector (employer health plans, Medicare, etc.), rather than a small sample of health plans;
b) the data are collected and reported by a Government entity;
c) the NHE trends are widely cited;
d) the NHE data are readily available by the categories and sub-categories described above; and
e) CMS provides both projections of the NHE trends and subsequent actual trends.

Further information on the NHE data can be found at http://www.cms.hhs.gov/NationalHealthExpendData

H.2.3.3.2. The NHE data are reported on a calendar year basis. For purposes of this incentive, the trend for the calendar year that overlaps the first 9 months of a given option period will be used as the comparison trend for that option period (e.g., the CY10 CMS NHE trend will be used as the standard for the incentive result for Option Period 1).

H.2.3.3.3. The actual CMS NHE data for a given calendar year are available approximately 15 months after the end of that calendar year (e.g., actual data for CY06 are expected to be available by March 2008). The Government will perform the calculation of this incentive result after the actual data are available. For the incentive calculation, to be performed at a minimum of 17 months after the end of each option period, the actual NHE trend reported by CMS for the relevant calendar year will be used based on the NHE data available at the time the final incentive calculation is performed.

H.2.3.3.4. Prior to comparing the observed trend experienced for the underwritten cost for Contractor Network Prime enrollees to the national external standard (the NHE per capita trend described above), the actual underwritten cost for the region trend will be adjusted for the approximate effects of three potential factors: 1) changes in the Contractor network share of MHS workload for this population; 2) changes in the number of Contractor Network Prime enrollees; and 3) contract change orders.

H.2.3.3.5. To adjust for changes in the Contractor network share of MHS workload, the Government will calculate, retrospectively, the Contractor network and MTF percentages of MHS workload for Contractor Network Prime enrollees in the option period being measured and in the preceding option period. TEDs data will be used to tabulate the number of Contractor network inpatient admissions and outpatient visits; MTF Standard Inpatient Data Records (SIDRs) will be used to tabulate the number of MTF inpatient dispositions; and MTF Standard Ambulatory Data Records (SADRs) will be used to tabulate the number of MTF outpatient encounters. The trend in the Contractor network share of MHS workload, per Contractor Network Prime enrollee, will be calculated as the ratio of the percentage of Contractor network care in the option period being measured to the corresponding percentage in the preceding option period and will be netted from the overall trend in underwritten cost per Contractor Network Prime enrollee. More details and an example of this calculation are provided in Attachment J-6, Hypothetical Example of the External Trend Incentive Calculation.

H.2.3.3.6. The actual trend can also be affected by a change in the share of Active Duty Dependents (ADDs) or Non-Active Duty Dependents (NADDs) in the Contractor Network Prime population. To normalize the observed trend in TRICARE underwritten health care costs for changes in the number of ADFM and/or NADFM Contractor Network Prime enrollees, relative to the prior year, the cost trend per enrollee, after being normalized for changes in the Contractor network share of workload, will be multiplied by the prior year's underwritten costs, separately for Active Duty Family Members (ADFMs) and Non-Active Duty Family Members (NADFMs). More details and an example of this calculation are provided in Attachment J-6.

H.2.3.3.7. Benefit changes unique to TRICARE can also affect the actual trend in cost per Contractor Network Prime enrollee. The impact of contract change orders on underwritten costs for Contractor Network Prime enrollees will also be netted from the underwritten cost trend prior to comparison to the CMS NHE standard. This will be done independently by the Government based on the best estimates and information available to the Government at the time this incentive calculation is performed. For the purpose of calculating this incentive, the Contracting Officer will have sole discretion to determine the cost impacts of change orders. More details and an example of this calculation are provided in Attachment J-6.

H.2.3.3.8. Once the underwritten cost trend per Contractor Network Prime enrollee has been normalized for these three factors cited under H.2.3.3.4. above, the normalized trend will be compared to the NHE cost trend described above. The normalized underwritten trend will be subtracted from the NHE trend, and the Contractor's incentive result will be 30% of the difference between the two trends. If the normalized underwritten trend is lower than the NHE trend described above, there will be a positive trend differential and the Contractor will receive a positive incentive result. If the normalized underwritten trend is higher than the NHE trend, there will be a negative trend differential and the Contractor will receive a negative incentive result. For example, if the normalized underwritten trend is 7.0% and the NHE trend is 6.0%, the Contractor will receive a negative 0.30% incentive result. If the normalized underwritten trend is 5.0% and the NHE trend is 6.0%, the Contractor will receive a positive incentive of 0.30%. To convert the incentive result into a dollar amount, the percentage result will be multiplied by the normalized underwritten cost for Contractor Network Prime enrollees that is calculated in Step 7 of this trend methodology (see Attachment J6 for the detailed steps in calculating this incentive).

H.2.3.3.9. This incentive will be calculated for each option period of the contract based on the begin date of care. For the Option Period 1 calculation, the prior year's data used as part of the calculation will reflect the data from the last year of the succeeded contract. Thus, the incoming Contractor's incentive result for Option Period 1 will reflect the trend in underwritten costs for Contractor Network Prime enrollees from the last year of the succeeded contract to the first option period of this contract, subject to the adjustments and external trend comparison described above.

H.2.3.3.10. For purposes of this incentive calculation, the underwritten costs tabulated from TED data will not be adjusted for the results of the allowable cost audits, for three reasons. First, this simplifies administration of this incentive. Second, not adjusting for the audit in this trend measurement gives the Contractor an additional incentive to improve claims processing accuracy. Third, the audit results may not be stratified specific to Contractor Network Prime enrollee claims.

H.3. PERFORMANCE INCENTIVES

H.3.1. Introduction: Monetary performance incentives are available to the Contractor. The Contractor may receive a positive performance incentive payment by either exceeding a minimum standard, or for performance above a fully satisfactory level in any of three areas: clinical quality; program integrity; and electronic claims as defined in this section for each respective option period. If the Contractor fails to meet the minimum standard for electronic claims processing, a negative incentive is applied.

H.3.1.1. Incentive Administration: Contractor performance for a given option period will be measured after completion of each option period. When performance exceeds the standard, or exceeds the fully satisfactory level described below, the Government administratively obligates funding on the applicable performance incentive contract line item in Section B. If the Contractor fails to meet the minimum standard for electronic claims processing, the funding level on the performance incentive contract line item may be netted, or the payments from the performance incentive contract line item offset by the applicable negative incentive amount described in this section. If the offset amount is greater than any earned incentive (if any), the Contracting Officer will deduct that amount from the next payment from any administrative line item to the Contractor under this contract. After the Government has completed measurement, and the Contracting Officer notifies the Contractor, the Contractor may invoice the net amount authorized by the Contracting Officer. The Government may obligate funds into the performance incentive pool at any time as the Contracting Officer determines necessary to ensure sufficient funds are available to pay performance incentives under H.2 and H.3 to the Contractor after the option period is completed.

H.3.2. Clinical Quality Incentive: Clinical quality will be measured on a region-wide basis using seven performance metrics which are similar to Healthcare Effectiveness Data and Information Set (HEDIS®) "Effectiveness of Care" measures.

1. Cervical Cancer Screening
2. Breast Cancer Screening
3. Asthma Use of Medication
4. Colorectal Screening
5. Diabetes Management A1c testing
6. Diabetes Management Lipid testing
7. Diabetes Management Retinal Screening

These seven HEDIS® -like measures will be calculated by the Government from administrative data using current technical specifications for all Prime Network enrolled patients in the relevant region. A description of and technical information on the performance metrics are at Attachment J-5, Clinical Quality Incentive Performance Metrics. The Government calculated HEDIS® -like measures will be provided to the Contractor at the beginning and end of each 12 month evaluation period. The Contractor may earn an incentive based on the Government's measurement of performance improvement over each one-year option period. The regional performance on each measure for the last 12 months preceding the start of health care delivery will serve as the baseline for the first option year following onset of delivery of health services under new contracts. The annual incentive award, if any, is final upon notification by the Contracting Officer.

H.3.2.1. The monetary incentive will be based on improvement (expressed as a percentage) in each measure over each one-year option period. Beneficiaries with other health insurance will be excluded from the baseline measurement and re-measurement. Independent monetary awards may be earned annually for each measure as follows:

Measure	≥ 1% improvement	≥ 3% improvement	≥ 5% improvement
Cervical Screening	$476,190	$952,380	$1,428,571
Breast Cancer Screening	$476,190	$952,380	$1,428,571
Asthma Medication	$476,190	$952,380	$1,428,571
Colorectal Screening	$476,190	$952,380	$1,428,571
Diabetes A1C testing	$476,190	$952,380	$1,428,571
Diabetes Lipid testing	$476,190	$952,380	$1,428,571
Diabetes Retinal Exam	$476,190	$952,380	$1,428,571

(Example: OP1 Colectoral Screening = 60%
OP2 = 60% + 3% = 63%

H.3.2.2. The Government may unilaterally add additional administrative HEDIS® "Effectiveness of Care" measures in future option periods. If additional measures are added, the total monetary amount available under this incentive (shown in H.3.2.1 above) will be redistributed among all measures.

H.3.3. Program Integrity Incentive: The Government will evaluate the referral of fraud and abuse cases referred during each respective option period and determine if the Contractor satisfactorily met all minimum requirements contained in each of the following sections of TRICARE Operations Manual (TOM) Chapter 13:

Section 1	Contractor's Responsibility in Program Integrity
Section 2	Case Development and Action
Section 3	Prevention and Detection
Section 4	Evaluation
Section 5	Reporting
Section 6	Provider Exclusions, Suspensions and Terminations
Section 7	Provider Reinstatements
Section 8	Threats against Contractors

H.3.3.1. The Contractor will earn a performance incentive if performance results in referral of over 10 complete cases to the TMA Office of Program Integrity during each option period that are rated "5" on a quality scale.

H.3.3.2. The monetary incentive amount applied to the performance incentive pool will be as follows:

11-15 cases referred with a "5" rating assigned:	$180,000.00
16-20 cases referred with a "5" rating assigned:	$240,000.00
21 or more cases referred with a "5" rating assigned:	$300,000.00

H.3.3.2.1. Rating criteria: The rating of the individual cases will be based on the Government's analysis of the case referral as follows: does the case identify a pattern of fraud or abuse; have the allegations been substantiated; how has

TRICARE been affected (monetarily, patient harm, etc); is the case referral complete (thoroughly documented with evidentiary data); was appropriate back-up information included (audit files, provider files, correspondence, etc); and was the applicable TRICARE regulation and/or policy cited and included in the package. The PI "Case Referral Evaluation" sheet will be used to rate each referral and can be found at TOM Chapter 13, Addendum A. All case ratings will be determined by the Government solely based on the information within the initial case submittal. Any information, rebuttals, or arguments provided by the Contractor subsequent to the initial submittal of a case will not be considered for the rating determination. Any case prepared, dated, or submitted prior to the start date of the delivery of care under this contract will not be considered for this incentive. If, in the opinion of the Contracting Officer, a newly referred case should reasonably have been referred under a separate contract, that case will not be considered for an incentive. The rating assignment by the Contracting Officer is final and unappealable.

H.3.4. Electronic Claim Submission Positive Incentive: The minimum electronic claims EMC submission performance standard is specified in Section C, paragraph CP.4.

H.3.4.1. After the appropriate paper claim exclusion percentage has been applied, if the Contractor exceeds the minimum performance standard, the amount of the incentive will be applied as follows:

H.3.4.1.1. For Option Period 1: $1.00 for every EMC claim which exceeds the minimum performance standard so long as the difference between the Contractor's EMC rate and paper claim rate is $1.25 or greater. If the difference in the EMC and paper claim rate is less than $1.25, then the incentive amount will be 80% of such difference for every EMC claim which exceeds the minimum performance standard.

H.3.4.1.2. For Option Periods 2 through 5: $1.25 for every EMC claim which exceeds the minimum performance standard so long as the difference between the Contractor's EMC rate and paper claim rate is $1.56 or greater. If the difference in the EMC and paper claim rate is less than $1.56, then the incentive amount will be 80% of such difference for every EMC claim which exceeds the minimum performance standard.

H.3.4.2. Electronic Claim Submission Negative Incentive: If the Contractor does not meet the minimum standard, positive and negative incentives will be netted, or any payment offset by the amount equal to the difference between the EMC claim rate and the paper claim rate for every claim that is below the minimum performance standard. (For example, if the Contractor is two percentage points below the minimum standard, the monetary negative incentive will be applied to two percent of the total claims not including those claims that were excluded as part of the paper claims percentage exclusion.)

H.3.4.3. The EMC submission performance rate will be determined based on data in the TEDs data base at the conclusion of an option period for claims that passed all TEDs edits during that option period regardless of the date of service or when the Contractor submits the TED record. The calculation will include initial TED records (TED type of submission equal to I, R, O or D) and will exclude any TED record with a provider in a foreign country or in the State of Alaska.

H.4. PERFORMANCE GUARANTEES

H.4.1. The performance guarantee described in this Section is the Contractor's guarantee that the Contractor's performance will not be less than the performance standards described below. The rights of the Government and remedies described in the Performance Guarantee Section are in addition to all other rights and remedies of the Government. Specifically, the Government reserves the rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4, 52.246-5) and the Default clause (FAR 52.249-8, 52.249-6).

H.4.2. The Contractor guarantees that performance will meet or exceed the standards in this Section. For each occurrence the Contractor fails to meet each guaranteed standard, the Government will withhold from the Contractor the amount listed for each standard below. The total performance guarantee amount that can be assessed per option period is shown below. The total option period amount will be divided equally among the six performance guarantees. Assessments for a specific performance guarantee will continue until the guarantee amount for the respective guarantee (i.e., one-sixth of the total option period amount) is depleted. For administrative purposes, the Contractor will be notified of performance guarantee withholds on a quarterly basis via a unilateral modification in accordance with FAR 43.103(b)(3) with this section as the cited authority for the modification. Withholds will be made from the next available contract payment under an administrative line item. The amount of the performance guarantee will not change after contract award.

H.4.3. Performance Guarantee Amounts:

Option Period 1 (b) (4)
Option Period 2
Option Period 3
Option Period 4
Option Period 5

H.4.4. Telephone Service (Telephone Answering Speed)

H.4.4.1. Standard: When a telephone call is transferred to/answered by an individual, 90% of all calls shall be answered by an individual (not an answering machine/automated voice unit) within 30 seconds.

H.4.4.2. For each month the minimum telephone answering speed is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee of $0.50 per telephone call not meeting the standard. For example, if the actual percent of calls answered within 30 seconds is 87%, then a performance guarantee equal to 3% of the calls will be assessed (3% represents the difference between the actual number of calls not answered within 30 seconds and the standard). If 3% equates to 1000 calls not meeting the standard, the performance guarantee withhold will be $500.00, or 1000 calls times $0.50.

H.4.4.3. All calls is defined as any call to any Contractor operated TRICARE customer service telephone number. Customer service shall be interpreted in the broadest terms including, but not limited to, calls from beneficiaries, providers, Government representatives, and interested parties about general program information, network providers, enrollment, eligibility, benefits, referrals, preauthorization's/authorizations, claims, complaints, processes and procedures.

H.4.5. Telephone Service (Initial Call Resolution Rate).

H.4.5.1. Standard: 85% of all inquiries shall be fully and completely answered during the initial telephone call. (Applies to all calls transferred to an individual.)

H.4.5.2. For each month the call resolution rate is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee amount of $0.50 for each call that is not fully and completely answered during the initial telephone call that is below the 85% standard. For example, if the actual percent of calls fully and completely answered during the initial call is 83%, then a performance guarantee equal to 2 percent of the calls not responded to will be assessed (2% represents the difference between the actual number of calls not answered during the initial call and the standard). If 2% equates to 500 calls not meeting the standard, the performance guarantee withhold will be $250.00, or 500 calls times $0.50.

H.4.6. Telephone Service (Call Resolution)

H.4.6.1. Standard: 99.5% of all telephone inquiries not fully and completely answered initially shall be fully and completely answered within 10 workdays.

H.4.6.2. For each month the standard is not met, a performance guarantee shall be applied as follows: Based on the Contractor's monthly telephone report, the Government will assess a performance guarantee amount of $0.50 for each call that is not fully and completely answered within 10 workdays that is below the above standard of 99.5%. For example, if the actual percent of calls not fully and completely answered within 10 workdays is 99%, then a performance guarantee equal to 0.5% of the calls not responded to will be assessed (0.5% represents the difference between the actual number of calls not answered within 10 workdays and the standard). If 0.5% equates to 100 calls not meeting the standard, the performance guarantee withhold will be $50.00, or 100 calls times $0.50.

Note: A performance guarantee assessment will be applied independently to each call resolution standard for telephone calls that fail to meet the minimum performance. For example, a telephone call that received a performance withhold because the 85% standard was not met, is again subject to withhold if it is not responded to within 10 workdays (and the Contractor's performance is below the minimum standard of 99.5%).

H.4.7. Claims Processing Timeliness (30 days)

H.4.7.1. Standard: 98% of retained claims and adjustment claims shall be processed to completion within 30 calendar days from the date of receipt.

H.4.7.2. For each month that the claims processing timeliness standard is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, the Government will assess a performance guarantee amount of $1.00 per retained claim in excess of the 98% standard. For example, if the actual percent of retained claims processed in 30 calendar days is 94%, a performance guarantee equal to 4% of the retained claims processed that month will be assessed (4% represents the difference between the actual performance of 94% and the standard of 98%). If 4% equates to 600 retained claims not processed in 30 calendar days, the performance guarantee withhold will be $600.00, or 600 times $1.00.

H.4.7.3. The Government will calculate the contractor claims processing cycle time performance utilizing TED records. Included in the monthly measurement will be TED records in initial submission batch/vouchers (Batch/Voucher Resubmission Number equals zero), and TED records in adjustment/cancellation submission batch/vouchers, which are received by TMA during the reporting period, and that have passed the TMA batch/voucher header edit(s). TED records in initial submission batch/vouchers, or TED records in adjustment /cancellation submission batch/vouchers, which fail the TMA batch/voucher header edits or which are otherwise unprocessable as submitted by the Contractor, and TEDS in resubmission batch/vouchers (Batch/Voucher Resubmission Number is greater than zero), will be excluded from the claims processing cycle time calculation. Only a single processing time will be calculated per claim. The cycle time calculation for initial submission TED records is one plus the difference between the Julian date the claim processed to completion, and the claim receipt date. The cycle time calculation for TED adjustments is one plus the difference between the Julian date the TED record was identified as an adjustment (Date Adjustment Identified not zero), and the date the adjusted record processed to completion.

H.4.8. Claim Processing Timeliness (90 Days)

H.4.8.1. Standard: 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days unless the Government specifically directs the Contractor to continue pending a claim or group of claims.

H.4.8.2. For each month that the claims processing timeliness standard is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, the Government will assess a performance guarantee amount of $1.00 per claim in excess of the 100% standard. For example, if the actual percent of all claims processed in 90 calendar days is 98%, a performance guarantee equal to 2% of all claims processed that month will be assessed (2% represents the difference between the actual performance of 98% and the standard of 100%). If 2% equates to 450 claims not processed in 90 calendar days, the performance guarantee withhold will be $450.00, or 450 times $1.00.

H.4.8.2.1. A performance guarantee assessment will be applied independently to each claim processing timeliness standard for claims that fail to meet the minimum performance. For example, a retained claim that received a performance withhold because the 98% in 30-day standard was not met, is again subject to withhold if it is not processed in 90 calendar days (and the Contractor's performance is below the minimum standard of 100%).

H.4.8.3. The Government will calculate the contractor claims processing cycle time performance utilizing TED records. Included in the monthly measurement will be TED records in initial submission batch/vouchers (Batch/Voucher Resubmission Number equals zero), and TED records in adjustment/cancellation submission batch/vouchers, which are received by TMA during the reporting period, and that have passed the TMA batch/voucher edit(s). TED records in initial submission batch/vouchers, or TED records in adjustment/cancellation submission batch/vouchers, which fail the TMA batch/voucher header edits or which are otherwise unprocessable as submitted by the Contractor, and TEDS in resubmission batch/vouchers (Batch/Voucher Resubmission Number is greater than zero), will be excluded from the claims processing cycle time calculation. Only a single processing time will be calculated per claim. The cycle time calculation for initial submission TED records is one plus the difference between the Julian date the claim processed to completion, and the claim receipt date. The cycle time calculation for TED adjustments is one plus the difference between the Julian date the TED record was identified as an adjustment (Date Adjustment Identified not zero), and the date the adjusted record processed to completion.

H.4.9. TED Edit Accuracy

H.4.9.1. Standard: The accuracy rate for TED edits shall not be less than
90% in months seven through nine;
95% in months ten through eleven
96% in months twelve through twenty-three
97% in month twenty-four through contract close.

H.4.9.2. Beginning in month seven of Option Period 1, for each month that the accuracy rate for TED edits is not met, a performance guarantee shall be applied as follows: Based on data from the TMA TEDs data base, if the Contractor fails to meet the standard, a performance guarantee amount of $3.00 for each TED record not meeting the standard will be assessed. For example, if only 85% of all TEDs pass editing in month seven, then a performance guarantee amount equal to 5% of all TEDs submitted during the month will be assessed (5% equals the difference between the Contractor's actual performance and the standard in this example). If 5% equates to 1,000 TEDs, the performance guarantee amount will be $3,000.00 or 1,000 times $3.00.

H.5. EVOLVING PRACTICES, DEVICES, MEDICINES, TREATMENTS AND PROCEDURES

H.5.1. Medical practices and procedures are expected to continue developing during the period of this contract: some will increase and some will decrease the cost of medical care. These changes will include practices, devices, medicines, treatments and procedures that previously were excluded from the benefits as unproven. The Contractor underwrites the cost of all drugs covered under this contract; and devices, and medical treatments or medical procedures that move from unproven to proven; and shall implement the move from unproven to proven as required at no change in contract price or underwriting fixed fee. Changes to the requirements caused by changes in the statutory definitions of the benefit or new benefits added by statute will be implemented under the Changes clause.

H.5.2. TRICARE can only cover costs only for medically necessary supplies and services. Regulatory procedures are in place at 32 C.F.R. 199.4(g)(15) that describe the procedure for evaluating the safety and efficacy of unproven drugs, devices, medical treatments, or medical procedures. The Contractor shall be responsible for routinely reviewing the hierarchy of reliable evidence, as defined in 32 C.F.R. 199.2.

H.6. INTEGRATED PROCESS TEAMS

H.6.1. The Government may develop major contract and program changes through Integrated Process Teams (IPTs). IPTs will not be formed for all contract changes, but generally will be formed for complex, system-wide issues. The IPT process required in this section begins the date when the Contracting Officer notifies the Contractor in writing. The Contractor will provide the appropriate personnel (as agreed to by the Contracting Officer and the Contractor) to serve on IPTs to develop and/or improve the technical, business, and implementation approach to any proposed TRICARE program contract changes within 14 calendar days after written notification by the Contracting Officer.

H.6.2. The Contractor shall participate in all required meetings as determined by the Government team lead within the change milestones described in this section, regardless of how they are held (in person, via teleconference, by video-teleconference, or through electronic conferences). The frequency and scheduling will vary depending on the topic. The Contractor will participate with the Government team in the entire process from concept development through the final requirement. The IPT process required in this section includes developing the Government's budgetary cost estimates, identifying requirements, developing associated rough order of magnitude cost estimates, and preparing the final specification/statement of work. The IPT process required in this section will end at this point, thus this requirement does not include post-change order activities, such as implementation/coordination meetings, and definitization efforts, whose costs are allocable to the change.

H.7. AWARD FEE

The award fee will be administered two times per contract option period (semi-annually) in accordance with the award fee plan. The award fee pool is as shown in Section B and awarded portions, if any, will be disbursed two times a contract option period. Unawarded portions of the award fee pool do not carry forward and are not available for any subsequent award fee period. The amount of the award fee pool will not change after contract award.

H.8. ASSUMPTION OF PERFORMANCE IN A SECOND TRICARE CONTRACT AREA

TRICARE is a statutory entitlement program under which there can be no lapse in program execution or interruption of services. It is the Government's duty to take all reasonable steps to ensure the ready availability of alternative contract sources to facilitate stability in delivery of this statutory entitlement program, help avoid unnecessary disruption in healthcare provider and patient relationships, and insure continuation of critical health services. Recognizing the potential that circumstances may arise under which the Government may require an alternative Contractor to assume, on an interim basis, contract performance in one of the three TRICARE contract areas, the Government will consider other options, including substituting contract performance by one or both of the other Contractors pending competitive acquisition of a successor. The Government agrees to negotiate in good faith a fair and reasonable compensation for the additional work to be performed. The Contractor retains all rights to equitable adjustments under the Changes clause in this matter.

H.9. CLAIMS PROCESSING AUDIT SAMPLING METHODOLOGY

H.9.1. Quarterly Claim Audit Sampling Methodology and Error Determinations.

H.9.1.1. Sampling Methodology: There will be three types of audit samples: one occurrence sample and two payment samples (one for non-denied claims and one for denied claims). The occurrence samples will be drawn from TEDs records which pass TMA validity edits. Records to be sampled will be "net" records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). The payment samples will be drawn from TEDs records which pass all TMA edits. Payment samples will be drawn from all records with Government payments or billed amounts greater than zero and less than $200,000, although the Government may choose to exclude certain claims strata from the sampling frame. In addition, the Government will conduct a one-hundred percent (100%) audit of all claims with payment amounts or billed amounts of over $200,000. Payment samples will be stratified at multiple levels, either by payment amount, billed amount or by other claims-based parameters, such as type of care and/or type of provider. Records to be sampled for both the occurrence and payment audits will be "net" records (i.e., the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in batches/vouchers which fail TRICARE edits or which are otherwise unprocessable as submitted by the Contractor will be excluded from the sampling frame.

H.9.1.2. Required Contractor Documentation: Upon receipt of the TEDs Internal Control Number (ICN) listing and TED Detail Audit Report (TADR) from TMA the Contractor shall retrieve and compile processing documentation for each selected claim. All documentation must be received at TMA or designated audit Contractors within forty five (45) calendar days from the date of the TMA letter transmitting the ICN and TADR listing. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service.

H.9.1.2.1. Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, and other telephone conversation records.

H.9.1.2.2. Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate(s), per diem rate(s), state prevailing fee(s) or fee schedule(s), DRG, OPPS, SNF, pricing information and such other documents as are required to support the action taken on the claim.

H.9.1.2.3. A copy of the Explanation of Benefits (EOB) (or EOB facsimile) for each claim selected.

H.9.1.2.4. The Contractor shall send via electronic data input the current family history (15 to 27 months) for each selected claim. This electronic data containing all required data fields must be received by TMA or the designated audit Contractor within forty five (45) calendar days from the date of the TMA or designated audit Contractor letter transmitting the ICN and TADR listing.

H.9.1.2.5. Payment or occurrence errors will be assessed if a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable. For TEDs which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit Contractors will return original documents upon completion of the audit process.

H.9.1.2.6. Additional data to be furnished by the Contractor.

H.9.1.2.6.1. Description of data elements by field position in family history file printout and field definitions for pricing, OHI, authorization, referral screens. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

H.9.1.2.6.2. Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

H.9.1.2.6.3. Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the 5th work day of the month following the change.

H.9.1.2.6.4. Specifications for submission of the provider files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

H.9.1.2.6.5. Documentation for any claim selected with adjustment transactions completed prior to the date of the sample must include the documentation to indicate both initial and adjustment processing actions to include claims EOBs, and pricing information.

H.9.1.2.6.6. Documentation to support beneficiary approved participation in any TMA demonstration programs.

H.9.2. Quarterly Payment Error and Process Error Determinations.

H.9.2.1. There are two categories of payment errors: (1) a payment error which cannot be removed by Contractor post payment processing actions and (2) a payment error which can be removed by Contractor post payment processing actions (see list of audit error codes defining payment error categories). Payment errors which can be removed by Contractor post payment actions will also be assessed a process error at audit. If Contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect payment or occurrence error rates, but will be used as a performance indicator.

H.9.2.2. Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a non-covered service/supplies, or services/supplies for which a benefit determination cannot be based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed medical emergency not substantiated, medical necessity review not evident and is cited in conjunction with a payment error. Process error determinations are based on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled.

H.9.2.3. Payment errors which may not be removed by Contractor post payment actions (see audit error categories) are based only on the claim information available and those processing actions which occur prior to the date the audit sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the audit sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to include the action taken and the date the action was completed is submitted with audit documentation. Action determinations occurring after the date the audit sample is pulled will not be considered in the audit regardless of whether resolution of payment error exists. Adjustment transactions are not allowed on total claim denials. Therefore, subsequent reprocessing actions to a denied claim which occur prior to the date the audit sample is pulled will be considered during the audit.

H.9.2.4. All incorrectly coded financial fields on a TED are considered to be occurrence errors regardless of whether associated errors exist.

H.9.3. Computation of the "Total Amount Billed" for Non-Denied Institutional Claims.

H.9.3.1. For treatment encounters for which no per diem, negotiated rate or DRG-based amount applies for consideration of payment, the "total amount billed" is the actual amount billed on the claims. This applies to treatment encounters involving services from DRG-exempt hospitals and hospital units, those involving DRG-exempt services and those which would otherwise be subject to the DRG-based payment methodology but for which a DRG allowed amount cannot be computed, regardless of whether or not these claim are paid.

H.9.3.2. For treatment encounters subject to the TRICARE per diem payments, negotiated rate, or the DRG-reimbursement methodology, the "total amount billed" is the correct per diem, negotiated rate, or DRG-based allowable amount including any applicable outlier amounts.

H.9.3.3. If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total amount billed will be assessed. For health care services records which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total amount billed. This condition is considered to be an unsupported TED.

H.9.3.4. The following are payment errors on which post payment actions are either not applicable or would not remove the payment errors assessed.

01K-Authorization/PreAuthorization needed (all — except (ECHO)* and Adjunctive Dental Authorizations)
03K-Billed Amount Incorrect

04K-Cost-share / Deductible Error
07K- Duplicate Services Paid
08K- Eligibility Determination — Patient
09K- Eligibility Determination — Provider
12K- Non-Availability Statement Error
13K-OHI/TPL — Govt. Pay Miscalculated
14K-OHI Payment Omitted
15K-Payee Wrong-Sponsor/Patient
16K- Payee Wrong- Provider
17K- Participating/Non-Participating Error
18K- Pricing Incorrect
19K-Procedure Code Incorrect
20K-Signature Error
22K-DRG Reimbursement Error
24K-Incorrect Benefit Determination
25K-Claim Not Provided
26K-Claim Not Auditable
27K-Incorrect MCS System

H.9.3.5. The following are payment errors on which post-payment actions may support original processing. On rebuttal, if documentation is provided that supports the processing actions, the payment errors could be removed but the process errors would remain.

01K-Authorization/Pre-Authorization Needed (ECHO* and adjunctive dental authorizations)
02K-Unsupported Benefit Determination
05K-Development Claim Denied Prematurely
06K-Development Required
10K-Medical Emergency Not Substantiated
11K-Medical Necessity/Review Not Evident
21K-Timely—Filing Error
23K-Contract Jurisdiction Error
99K-Other - This payment error is very general and claims would have to be reviewed on an individual basis with regard to post-payment actions.

*ECHO – Extended Care Health Option

H.9.4. Quarterly TED Occurrence Error Determination.

H.9.4.1. The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample times 100.

H.9.4.2. Occurrence errors determinations are based on only the claim information available and those processing actions taken at the time of adjudication. Actions and determinations occurring subsequent to the processed date of an audited claim, such as obtaining other health insurance documentation, adjusting a claim to correct financial or other data fields, or developing for required information not obtained prior to processing, are not a consideration of the audit regardless of whether a resolution of the incorrectly coded TED results.

H.9.4.3. Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including errors in financial fields, shall be counted as occurrence errors.

H.9.4.4. Some TED error conditions are not attributable to any one specific data field but apply to the record as a whole or to certain parts of the record. In addition to erroneous data field coding, the following error conditions involving incorrect or unsupported records will result in occurrence errors being assessed as indicated.

H.9.4.5. The following are occurrence error categories and codes. All TED record occurrence errors, including errors in financial fields, are counted and the error rate is expressed as a percentage of the total number of data fields in the TED record. .

Error Categories	Errors Condition Specific to Data Field
A	Incorrect Claim Information

B	Incorrect Patient/Sponsor Information
C	Incorrect Provider Information
D	Incorrect Admission/Discharge Information (Institutional TED Records only)
E	Incorrect Diagnosis/Treatment Information (Institutional TED Records Only)
F	Incorrect Diagnosis Information (Non-Institutional TED Records Only)
G	Incorrect Financial Information
H	Incorrect Institutional Revenue Data
I	Incorrect Non-Institutional Claims/Provider/Utilization Information

Error Codes	Error Condition Specific to Claim	Number of Errors
01J	Unlike Procedures/Providers Combined (Non-institutional Record)	7 errors for each additional utilization data set*
02J	Unlike Revenue Codes Combined (Institutional Record)	5 errors for each erroneous revenue code set**
03J	Services Should Be Combined	1 error for each additional revenue code/utilization data set
04J	Missing Non-institutional Utilization Data Set	7 errors for each missing data set*
05J	Extra Non-institutional Utilization Data Set	7 errors for each extra data set*
06J	Missing Institutional Revenue Code Set	5 error for each missing revenue code set**
07J	Extra Institutional Revenue Code Set	5 errors for each extra revenue code set**
08J	Incorrect Record Type	5 errors
09J	Separate TED Record Required	1 error
10J	Claim Not Provided for Audit	1 error plus 1 error for each revenue code utilization data set in the TED
11J	Claim Not Auditable	1 error plus 1 error for each revenue code utilization data set in the TED
12J	Unsupported TED Transaction	1 error plus 1 error for each revenue code utilization data set in the TED

H.9.4.6. The following are process errors which will be assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors nor payment errors and are not used to calculate the occurrence error or payment error rate. A payment error will be assessed along with the process error. Upon rebuttal if the process is followed to conclusion and the actions support the original decision, the payment error will be removed but the process error will remain.

01P - Authorization/Pre-authorization needed (ECHO and adjunctive dental authorizations)
02P - Unsupported Benefit Determinations
05P - Development Claim Denied Prematurely
06P - Development Required
10P - Medical Emergency Not Substantiated
11P - Medical Necessity/Review Not Evident
21P - Timely Filing Error
23P - Contract Jurisdiction Error
99P - Other

H.9.5. Quarterly Payment and Occurrence Error Determination Rebuttals. Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality audit within 30 calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within 30 calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when during the audit rebuttal process the Contractor submits a claim not previously submitted with the audit and an error is assessed, or when the Contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the Contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit Contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated audit Contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 30 to the Julian calendar date of the TMA or designated audit Contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit Contractor rebuttal response letter.

H.10. UNDERWRITTEN HEALTH CARE COST AUDIT
(Reference FAR Clause 52.216-7, ALLOWABLE COST AND PAYMENT (DEC 2002) (DEVIATION)

H.10.1 TRICARE Encounter Data (TED) batch/voucher payment records are utilized to determine unallowable costs based on the results of this health care cost audit. The total unallowable amount is calculated on a per record basis, using all fields used to calculate a batch/voucher header total, and for dates of service falling within a specified option period. The total amount reimbursed by the Government will be calculated using all edited TEDs batch/vouchers with resubmission number equal to zero. At the time of the audit, batch/voucher records that have not passed validity edits on the TED record, or which are otherwise unprocessable as submitted by the Contractor, will be excluded from this audit sample. The Government reserves its rights under FAR 42.801 to disallow costs identified as unallowable through means other than the underwritten health care cost audit, when such costs are not included in the audit sample universe.

H.10.2. Sampling Methodology, Application of Results and Error Determinations.

H.10.2.1. For each option period, a stratified random sample of up to 10,000 claims from the universe of non-denied underwritten claims will be used to estimate the total overpayment amount in the claims universe. The point estimate (E) of questioned cost in the universe will be deemed the unallowable cost amount, provided that the lower bound (LB) of a one-sided ninety-percent (90%) confidence interval for E is at least 95% as large as E. Otherwise, LB will be deemed as the unallowable cost amount. All claims in the sample determined to have been underpaid will be deemed to have an overpayment amount of zero. At the discretion of the Government, the unallowable cost amount will be determined based on the estimated average overpayment per claim in the universe, the estimated ratio of overpayments to payments in the universe, or other commonly used estimation methods, in order to allow the Government to arrive at the best estimate of overpayments in the claims universe. The payment samples will be drawn from all records with Government reimbursement of greater than zero and less than $200,000, although the Government may choose to exclude certain claims strata from the sampling frame and from the claims universe. In addition, the Government will conduct a one-hundred percent (100%) audit of all claims with payment amounts of over $200,000. The unallowable cost amount found in this 100% audit will be added to the unallowable costs estimated based on the sampling of claims with payment amounts of under $200,000. Payment samples will be stratified at multiple levels, either by payment amount or by other claims-based parameters, such as type of care and/or type of provider.

H.10.2.2. Samples will be drawn from underwritten TED records that have passed all TED edits and that have processed into the TEDs database through the thirteenth month following the end of the each contract option period. The audit sample will be drawn from underwritten TED records with beginning dates of service within the option period in question. Records to be sampled will be "net" records (i.e., the sum of the option-period transaction records available). The Government will provide the Contractor, at the same time the sample is requested, a complete listing of all TED records that encompass the audit universe for each respective option period. At that time, the Contractor shall identify all TED records that are from non-underwritten claims and claims that were not within the dates of service range for the option period being audited. The Contractor shall provide a list of such claims, including any supporting documentation, not later than thirty (30) calendar days after receipt of the listing.

H.10.2.3. Required Contractor Documentation.

H.10.2.3.1. Upon receipt of the TEDs Internal Control Number (ICN) listing and TED Detail Audit Report (TADR) from TMA, the Contractor shall retrieve and compile processing documentation for each selected claim. All documentation must be received at TMA or designated audit Contractors within forty-five (45) calendar days from the date of the TMA letter transmitting the ICN listing. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service:

a) Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, and other telephone conversation records;

b) Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements, and 4) negotiated rate(s), per diem rate(s), state prevailing fee(s) or fee schedule(s), DRG, OPPS, or SNF pricing information, and such other documents as are required to support the action taken on the claim;

c) A copy of the EOB (or EOB facsimile) for each claim selected.

d) Documentation to support beneficiary approved participation in any TMA demonstration programs.

H.10.2.3.2. The Contractor shall also send, via electronic data input, the current family history (15 to 27 months) for each selected claim.

H.10.2.3.3. Documentation for any claim selected with adjustment transactions completed prior to the date of the sample must include the documentation to indicate both initial and adjustment processing actions, to include claims EOBs, and pricing information.

H.10.2.3.4. If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, 100 percent of the payment based upon the total Government Pay Amount will be deemed unallowable. For TEDs that do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, 100 percent of the payment amount will be deemed unallowable. The payment amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or the designated audit Contractors will return original documents upon completion of the audit process.

H.10.2.3.5. Other Deliverables. Paragraphs F.6.10 through F.6.10.4 in Section F describe the Contractor's claims processing data elements, guidelines, processes, screens, criteria, instructions, etc. that are required to be submitted during the base period of the contract. The Contractor shall submit any changes to these elements/guidelines/ processes/screens/criteria/instructions as they occur.

H.10.2.4. Payment Error Determinations.

H.10.2.4.1. The audit error codes (K codes) indicated in Section H.9, above will apply to the cost audit. Payment errors are based on the claim information available and those processing actions taken up to the time the audit sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the audit sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to indicate the action taken and the date the action was completed is submitted. Actions and determinations occurring after the date the audit sample is pulled will not be considered in the audit described in this section regardless of whether resolution of a payment error exists.

H.10.2.4.2. Payment errors are the amount of overpayments on a claim, including but not limited to misapplication of the deductible, payment of non-covered service/supplies, or payment of services/supplies for which a benefit cannot be determined based on the information available at the time of processing, or a payment in the correct amount but sent to the wrong payee. The measure of the payment error is the TED record.

H.10.2.5. Cost Audit Rebuttals.

H.10.2.5.1. Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality auditor within thirty (30) calendar days of the date of the audit transmittal letters. Rebuttals not submitted within thirty (30) calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when, during the audit rebuttal process, the Contractor submits a claim not previously submitted with the audit and an error is assessed, or when the Contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the Contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit Contractor during the initial rebuttal process must be submitted within 30 calendar days of the TRICARE or designated quality review Contractor rebuttal response letter. Rebuttals to new errors not submitted within 30 calendar days from the date of the original rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 30 to the Julian calendar date of the TMA or designated audit Contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit Contractor rebuttal response letter.

H.10.2.5.2. The rebuttal for the healthcare cost audit shall be certified by a responsible official of the Contractor as to accuracy and completeness. The rebuttal submission and the rebuttal process used by the Contractor may be reviewed by the Government.

H.10.3. Upon completion of the audit process, the Contracting Officer will notify the Contractor of the disallowed amount and will either deduct that amount from current payments, or provide other instructions for the return of the disallowed amount. When the Government has recovered from any disallowed amount; the Contractor is not required to return monies it subsequently recovered from third parties on any claims/TED records that were included in the universe from which the audit sample was drawn. See TOM Chapter 3, Section 3., Paragraph 2.2.2.

H.11. EXPRESSLY UNALLOWABLE HEALTH CARE COSTS

This contract identifies certain cost categories that are not underwritten health care costs. These are known as expressly unallowable underwritten health care costs. This includes, but is not limited to, the Contractor payments under Section

C, paragraph RM.2.1. and payments over the allowed amounts specified in the TRICARE Manuals. Any payment made by the Contractor that is expressly unallowable is borne by the Contractor and shall not be reported or billed as underwritten health care costs. The Contractor must account for these payments at the individual claim level. These unallowable amounts shall be available for review by the Contracting Officer or designee.

H.12. INSURANCE LIABILITY COVERAGES

In accordance with FAR 28.306(b) and as incorporated by reference in Section I, FAR 52.228-5, INSURANCE – WORK ON A GOVERNMENT INSTALLATION (JAN 1997), the following minimum liability coverages are stated below:

(a) *Workers' compensation and employer's liability.* The Contractor is required to comply with applicable Federal and State workers' compensation and occupational disease statutes. If occupational diseases are not compensable under those statutes, they shall be covered under the employer's liability section of the insurance policy, except when contract operations are so commingled with a contractor's commercial operations that it would not be practical to require this coverage. Employer's liability coverage of at least $100,000 shall be required, except in States with exclusive or monopolistic funds that do not permit workers' compensation to be written by private carriers. (See 28.305(c) for treatment of contracts subject to the Defense Base Act.)

(b) *General liability.*

(1) The contractor shall be required to provide bodily injury liability insurance coverage written on the comprehensive form of policy of at least $500,000 per occurrence.

(2) Property damage liability insurance shall be required only in special circumstances as determined by the agency.

(c) *Automobile liability.* The contractor shall be required to provide automobile liability insurance written on the comprehensive form of policy. The policy shall provide for bodily injury and property damage liability covering the operation of all automobiles used in connection with performing the contract. Policies covering automobiles operated in the United States shall provide coverage of at least $200,000 per person and $500,000 per occurrence for bodily injury and $20,000 per occurrence for property damage. The amount of liability coverage on other policies shall be commensurate with any legal requirements of the locality and sufficient to meet normal and customary claims.

H.13 ADDITIONAL PERFORMANCE REQUIREMENTS

The following requirements, standards, and processes are additional or more stringent than may otherwise be stated elsewhere in the contract.

(b) (4)

(b) (4)

(b) (4)

(b) (4)

(b) (4)

[redacted]

(b) (4)

52.252-2 Clauses Incorporated by Reference. (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address(es): http://farsite.hill.af.mil/
(End of clause)

52.202-1 Definitions. (JAN 2012)

52.203-3 Gratuities. (APR 1984)

52.203-5 Covenant Against Contingent Fees. (APR 1984)

52.203-6 Restrictions on Subcontractor Sales to the Government. (SEP 2006)

52.203-7 Anti-Kickback Procedures. (OCT 2010)

52.203-8 Cancellation, Rescission, and Recovery of Funds for Illegal or Improper Activity. (JAN 1997)

52.203-10 Price or Fee Adjustment for Illegal or Improper Activity. (JAN 1997)

52.203-12 Limitation on Payments to Influence Certain Federal Transactions. (OCT 2010)

52.203-13 Contractor Code of Business Ethics and Conduct. (APR 2010)

52.203-14 Display of Hotline Poster(s). (DEC 2007)

(a) Definition.

"United States," as used in this clause, means the 50 States, the District of Columbia, and outlying areas.

(b) Display of fraud hotline poster(s). Except as provided in paragraph (c)--

(1) During contract performance in the United States, the Contractor shall prominently display in common work areas within business segments performing work under this contract and at contract work sites--

(i) Any agency fraud hotline poster or Department of Homeland Security (DHS) fraud hotline poster identified in paragraph (b)(3) of this clause; and

(ii) Any DHS fraud hotline poster subsequently identified by the Contracting Officer.

(2) Additionally, if the Contractor maintains a company website as a method of providing information to employees, the Contractor shall display an electronic version of the poster(s) at the website.

(3) Any required posters may be obtained as follows:

Poster(s) Obtain from

(3) Any required posters may be obtained as follows:

DoD Inspector General, ATTN: Defense Hotline, 400 Army Navy Drive, Washington, DC 22202-2884.

Poster(s) Obtain by accessing the following website:

http://www.dodig.osd.mil/hotline/hotline7.htm

(c) If the Contractor has implemented a business ethics and conduct awareness program, including a reporting mechanism, such as a hotline poster, then the Contractor need not display any agency fraud hotline posters as required in paragraph (b) of this clause, other than any required DHS posters.

(d) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (d), in all subcontracts that exceed $5,000,000, except when the subcontract--

(1) Is for the acquisition of a commercial item; or

(2) Is performed entirely outside the United States.

(End of clause)

52.204-4 Printed or Copied Double-Sided on Recycled Paper. (MAY 2011)

52.204-7 Central Contractor Registration. (FEB 2012)

52.204-9 Personal Identity Verification of Contractor Personnel. (JAN 2011)

52.204-10 Reporting Executive Compensation and First-Tier Subcontract Awards. (FEB 2012)

52.209-6 Protecting the Government's Interest When Subcontracting with Contractors Debarred, Suspended, or Proposed for Debarment. (DEC 2010)

52.209-9 – Updates of Publicly Available Information Regarding Responsibility Matters. (FEB 2012)

(a) The Contractor shall update the information in the Federal Awardee Performance and Integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the Central Contractor Registration database https://www.acquisition.gov.

(b) As required by section 3010 of the Supplemental Appropriations Act, 2010 (Pub. L. 111-212), all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available. FAPIIS consist of two segments—

(1) The non-public segment, into which Government officials and the Contractor post information, which can only be viewed by—

(i) Government personnel and authorized users performing business on behalf of the Government; or

(ii) The Contractor, when viewing data on itself; and

(2) The publicly-available segment, to which all data in the non-public segment of FAPIIS is automatically transferred after a waiting period of 14 calendar days, except for--

(i) Past performance reviews required by subpart 42.15;

(ii) Information that was entered prior to April 15, 2011; or

(iii) Information that is withdrawn during the 14-calendar-day waiting period by the Government official who posted it in accordance with paragraph (c)(1) of this clause.

(c) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(1) If the Contractor asserts in writing within 7 calendar days, to the Government official who posted the information, that some of the information posted to the non-public segment of FAPIIS is covered by a disclosure exemption under the Freedom of Information Act, the Government official who posted the information must within 7 calendar days remove the posting from FAPIIS and resolve the issue in accordance with agency Freedom of Information procedures, prior to reposting the releasable information. The contractor must cite 52.209-9 and request removal within 7 calendar days of the posting to FAPIIS.

(2) The Contractor will also have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i.e., for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3) As required by section 3010 of Pub. L. 111-212, all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available.

(d) Public requests for system information posted prior to April 15, 2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures promulgated under E.O. 12600.

(End of clause)

52.210-1 Market Research. (Apr 2011)

52.211-15 Defense Priority and Allocation Requirements. (APR 2008)

52.215-2 Audit and Records - Negotiation. (OCT 2010)

52.215-8 Order of Precedence - Uniform Contract Format. (OCT 1997)

52.215-11 Price Reduction for Defective Certified Cost or Pricing Data - Modifications. (AUG 2011)

52.215-13 Subcontractor Certified Cost or Pricing Data - Modifications. (OCT 2010)

52.215-15 Pension Adjustments and Asset Reversions. (OCT 2010)

52.215-18 Reversion or Adjustment of Plans for Postretirement Benefits (PRB) Other Than Pensions (JUL 2005)

52.215-19 Notification of Ownership Changes. (OCT 1997)

(a) The Contractor shall make the following notifications in writing:

(1) When the Contractor becomes aware that a change in its ownership has occurred, or is certain to occur, that could result in changes in the valuation of its capitalized assets in the accounting records, the Contractor shall notify the Administrative Contracting Officer (ACO) within 30 days.

(2) The Contractor shall also notify the ACO within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership.

(b) The Contractor shall -

(1) Maintain current, accurate, and complete inventory records of assets and their costs;

(2) Provide the ACO or designated representative ready access to the records upon request;

(3) Ensure that all individual and grouped assets, their capitalized values, accumulated depreciation or amortization, and remaining useful lives are identified accurately before and after each of the Contractor's ownership changes; and

(4) Retain and continue to maintain depreciation and amortization schedules based on the asset records maintained before each Contractor ownership change.

(c) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR 15.408(k).

(End of Clause)

52.215-21 Requirements for Certified Cost or Pricing Data and Data Other than Certified Cost or Pricing Data—Modifications (OCT 2010)

52.215-21 III Requirements for Certified Cost or Pricing Data and Data Other than Certified Cost or Pricing Data—Modifications (OCT 1997)

(c) Submit the cost portion of the proposal via the following electronic media: *EXCEL (Microsoft)*

52.215-23 Limitations on Pass- Through Charges. (OCT 2009)

52.216-7 Allowable Cost and Payment. (JUN 2011)
(Applicable to all CLINs for Disease Management and Transition Out)

(a) *Invoicing.*

(1) The Government will make payments to the Contractor when requested as work progresses, but (except for small business concerns) not more often than once every 2 weeks, in amounts determined to be allowable by the Contracting Officer in accordance with Federal Acquisition Regulation (FAR) Subpart 31.2 in effect on the date of this contract and the terms of this contract. The Contractor may submit to an authorized representative of the Contracting Officer, in such form and reasonable detail as the representative may require, an invoice or voucher supported by a statement of the claimed allowable cost for performing this contract.

(2) Contract financing payments are not subject to the interest penalty provisions of the Prompt Payment Act. Interim payments made prior to the final payment under the contract are contract financing payments, except interim payments if this contract contains Alternate I to the clause at 52.232-25.

(3) The designated payment office will make interim payments for contract financing on the _________ [*Contracting Officer insert day as prescribed by agency head; if not prescribed, insert "30th"*] day after the designated billing office receives a proper payment request. In the event that the Government requires an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, the designated payment office is not compelled to make payment by the specified due date.

(b) *Reimbursing costs.*

(1) For the purpose of reimbursing allowable costs (except as provided in subparagraph (b)(2) of this clause, with respect to pension, deferred profit sharing, and employee stock ownership plan contributions), the term "costs" includes only --

(i) Those recorded costs that, at the time of the request for reimbursement, the Contractor has paid by cash, check, or other form of actual payment for items or services purchased directly for the contract;

(ii) When the Contractor is not delinquent in paying costs of contract performance in the ordinary course of business, costs incurred, but not necessarily paid, for --

(A) Supplies and services purchased directly for the contract and associated financing payments to subcontractors, provided payments determined due will be made—

(1) In accordance with the terms and conditions of a subcontract or invoice; and

(2) Ordinarily within 30 days of the submission of the Contractor's payment request to the Government;

(B) Materials issued from the Contractor's inventory and placed in the production process for use on the contract;

(C) Direct labor;

(D) Direct travel;

(E) Other direct in-house costs; and

(F) Properly allocable and allowable indirect costs, as shown in the records maintained by the Contractor for purposes of obtaining reimbursement under Government contracts; and

(iii) The amount of financing payments that have been paid by cash, check or other form of payment to subcontractors.

(2) Accrued costs of Contractor contributions under employee pension plans shall be excluded until actually paid unless—

(i) The Contractor's practice is to make contributions to the retirement fund quarterly or more frequently; and

(ii) The contribution does not remain unpaid 30 days after the end of the applicable quarter or shorter payment period (any contribution remaining unpaid shall be excluded from the Contractor's indirect costs for payment purposes).

(3) Notwithstanding the audit and adjustment of invoices or vouchers under paragraph (g) of this clause, allowable indirect costs under this contract shall be obtained by applying indirect cost rates established in accordance with paragraph (d) of this clause.

(4) Any statements in specifications or other documents incorporated in this contract by reference designating performance of services or furnishing of materials at the Contractor's expense or at no cost to the Government shall be disregarded for purposes of cost-reimbursement under this clause.

(c) *Small business concerns.* A small business concern may receive more frequent payments than every 2 weeks.

(d) *Final indirect cost rates.*

(1) Final annual indirect cost rates and the appropriate bases shall be established in accordance with Subpart 42.7 of the Federal Acquisition Regulation (FAR) in effect for the period covered by the indirect cost rate proposal.

(2) (i) The Contractor shall submit an adequate final indirect cost rate proposal to the Contracting Officer (or cognizant Federal agency official) and auditor within the 6-month period following the expiration of each of its fiscal years. Reasonable extensions, for exceptional circumstances only, may be requested in writing by the Contractor and granted in writing by the Contracting Officer. The Contractor shall support its proposal with adequate supporting data.

(ii) The proposed rates shall be based on the Contractor's actual cost experience for that period. The appropriate Government representative and the Contractor shall establish the final indirect cost rates as promptly as practical after receipt of the Contractor's proposal.

(iii) An adequate indirect cost rate proposal shall include the following data unless otherwise specified by the cognizant Federal agency official:

(A) Summary of all claimed indirect expense rates, including pool, base, and calculated indirect rate.

(B) *General and Administrative expenses (final indirect cost pool).* Schedule of claimed expenses by element of cost as indentified in accounting records (Chart of Accounts).

(C) *Overhead expenses (final indirect cost pool).* Schedule of claimed expenses by element of cost as identified in accounting records (Chart of Accounts) for each final indirect cost pool.

(D) *Occupancy expenses (intermediate indirect cost pool).* Schedule of claimed expenses by element of cost as identified in accounting records (Chart of Accounts) and expense reallocation to final indirect cost pools.

(E) Claimed allocation bases, by element of cost, used to distribute indirect costs.

(F) Facilities capital cost of money factors computation.

(G) Reconciliation of books of account (*i.e.*, General Ledger) and claimed direct costs by major cost element.

(H) Schedule of direct costs by contract and subcontract and indirect expense applied at claimed rates, as well as a subsidiary schedule of Government participation percentages in each of the allocation base amounts.

(I) Schedule of cumulative direct and indirect costs claimed and billed by contract and subcontract.

(J) *Subcontract information*. Listing of subcontracts awarded to companies for which the contractor is the prime or upper-tier contractor (include prime and subcontract numbers; subcontract value and award type; amount claimed during the fiscal year; and the subcontractor name, address, and point of contract information).

(K) Summary of each time-and-materials and labor-hour contract information, including labor categories, labor rates, hours, and amounts; direct materials; other direct costs; and, indirect expense applied at claimed rates.

(L) Reconciliation of total payroll per IRS form 941 to total labor costs distribution.

(M) Listing of decisions/agreements/approvals and description of accounting/organizational changes.

(N) Certificate of final indirect costs (see 52.242-4, Certification of Final Indirect Costs).

(O) Contract closing information for contracts physically completed in this fiscal year (include contract number, period of performance, contract ceiling amounts, contract fee computations, level of effort, and indicate if the contract is ready to close).

(iv) The following supplemental information is not required to determine if a proposal is adequate, but may be required during the audit process:

(A) Comparative analysis of indirect expense pools detailed by account to prior fiscal year and budgetary data.

(B) General Organizational information and Executive compensation for the five most highly compensated executives. See 31.205-6(p). Additional salary reference information is available at http://www.whitehouse.gov/omb/procurement_index_exec_comp/ .

(C) Identification of prime contracts under which the contractor performs as a subcontractor.

(D) Description of accounting system (excludes contractors required to submit a CAS Disclosure Statement or contractors where the description of the accounting system has not changed from the previous year's submission).

(E) Procedures for identifying and excluding unallowable costs from the costs claimed and billed (excludes contractors where the procedures have not changes from the previous year's submission).

(F) Certified financial statements and other financial data (*e.g.*, trial balance, compilation, review, etc).

(G) Management letter from outside CPAs concerning any internal control weaknesses.

(H) Actions that have been and/or will be implemented to correct the weaknesses described in the management letter from subparagraph (G) of this section.

(I) List of all internal audit reports issued since the last disclosure of internal audit reports to the Government.

(J) Annual internal audit plan of scheduled audits to be performed in the fiscal year when the final indirect cost rate submission is made.

(K) Federal and State income tax returns.

(L) Securities and Exchange Commission 10-K annual report.

(M) Minutes from board of directors meetings.

(N) Listing of delay claims and termination claims submitted which contain costs relating to the subject fiscal year.

(O) Contract briefings, which generally include a synopsis of all pertinent contract provisions, such as: Contract type, contract amount, product or service(s) to be provided, contract performance period, rate ceilings, advance approval requirements, pre-contract cost allowability limitations, and billing limitations.

(v) The Contractor shall update the billings on all contracts to reflect the final settled rates and update the schedule of cumulative direct and indirect costs claimed and billed, as required in paragraph (d)(2)(iii)(I) of this sections, within 60 days after settlement of final indirect cost rates.

(3) The Contractor and the appropriate Government representative shall execute a written understanding setting forth the final indirect cost rates. The understanding shall specify

(i) the agreed-upon final annual indirect cost rates,

(ii) the bases to which the rates apply,

(iii) the periods for which the rates apply,

(iv) any specific indirect cost items treated as direct costs in the settlement, and

(v) the affected contract and/or subcontract, identifying any with advance agreements or special terms and the applicable rates.

The understanding shall not change any monetary ceiling, contract obligation, or specific cost allowance or disallowance provided for in this contract. The understanding is incorporated into this contract upon execution.

(4) Failure by the parties to agree on a final annual indirect cost rate shall be a dispute within the meaning of the Disputes clause.

(5) Within 120 days (or longer period if approved in writing by the Contracting Officer) after settlement of the final annual indirect cost rates for all years of a physically complete contract, Contractor shall submit a completion invoice or voucher to reflect the settled amounts and rates. The completion invoice or voucher shall include settled subcontract amounts and rates. The prime contractor is responsible for settling subcontractor amounts and rates included in the completion invoice or voucher and providing status of subcontractor audits to the contracting officer upon request.

(6) (i) If the Contractor fails to submit a completion invoice or voucher within the time specified in paragraph (d)(5) of this clause, the Contracting Officer may--

(A) Determine the amounts due to the Contractor under the contract; and

(B) Record this determination in a unilateral modification to the contract.

(ii) This determination constitutes the final decision of the Contracting Officer in accordance with the Disputes clause.

(e) *Billing rates*. Until final annual indirect cost rates are established for any period, the Government shall reimburse the Contractor at billing rates established by the Contracting Officer or by an authorized representative (the cognizant auditor), subject to adjustment when the final rates are established. These billing rates --

(1) Shall be the anticipated final rates; and

(2) May be prospectively or retroactively revised by mutual agreement, at either party's request, to prevent substantial overpayment or underpayment.

(f) *Quick-closeout procedures*. Quick-closeout procedures are applicable when the conditions in FAR 42.708(a) are satisfied.

(g) *Audit*. At any time or times before final payment, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. Any payment may be --

(1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs; or

(2) Adjusted for prior overpayments or underpayments.

(h) *Final payment*.

(1) Upon approval of a completion invoice or voucher submitted by the Contractor in accordance with paragraph (d)(5) of this clause, and upon the Contractor's compliance with all terms of this contract, the Government shall promptly pay any balance of allowable costs and that part of the fee (if any) not previously paid.

(2) The Contractor shall pay to the Government any refunds, rebates, credits, or other amounts (including interest, if any) accruing to or received by the Contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government. Reasonable expenses incurred by the Contractor for securing refunds, rebates, credits, or other amounts shall be allowable costs if approved by the Contracting Officer. Before final payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver --

(i) An assignment to the Government, in form and substance satisfactory to the Contracting Officer, of refunds, rebates, credits, or other amounts (including interest, if any) properly allocable to costs for which the Contractor has been reimbursed by the Government under this contract; and

(ii) A release discharging the Government, its officers, agents, and employees from all liabilities, obligations, and claims arising out of or under this contract, except --

(A) Specified claims stated in exact amounts, or in estimated amounts when the exact amounts are not known;

(B) Claims (including reasonable incidental expenses) based upon liabilities of the Contractor to third parties arising out of the performance of this contract; provided, that the claims are not known to the Contractor on the date of the execution of the release, and that the Contractor gives notice of the claims in writing to the Contracting Officer within 6 years following the release date or notice of final payment date, whichever is earlier; and

(C) Claims for reimbursement of costs, including reasonable incidental expenses, incurred by the Contractor under the patent clauses of this contract, excluding, however, any expenses arising from the Contractor's indemnification of the Government against patent liability.

(End of Clause)

52.216-7 Allowable Cost and Payment. (DEC 2002) (DEVIATION)
(Applicable to CLINs for Underwritten Health Care Cost)

(a) Invoicing. (1) The Government will make payments to the Contractor when requested , but not more often than once every Government business day, in amounts determined to be allowable by the Contracting Officer in accordance with Federal Acquisition Regulation Subpart 31.201-6 and with the terms of this contract. The submission of health care costs on a TED voucher that pass the TED edits will be considered an invoice or voucher for reimbursement of claimed allowable health care costs.

(2) Contract financing payments are not subject to the interest penalty provisions of the Prompt Payment Act. Interim payments made prior to the final payment under the contract are contract financing payments, except interim payments if this contract contains Alternate I to the clause at 52.232-25.

(3) In the event that the Government requires an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, the designated payment office is not compelled to make payment by the specified due date.

(b) Reimbursing costs. For the purpose of reimbursing allowable costs, the term "costs" includes only --

(1)Those submitted on vouchers either for direct health care costs that, at the time the request for reimbursement has passed the TED edits; and,

(2) Those recorded costs that, at the time of the request for reimbursement, the Contractor has actually paid or made the expenditure by cash, check, electronic fund transfer, or other form of actual payment for health care under this contract and,

(3) Those costs eligible for reimbursement are the direct health care costs that pass TED edits involving health care furnished to an eligible beneficiary, health care authorized under TRICARE, health care furnished by an authorized TRICARE provider, and health care costs consistent with authorized TRICARE reimbursement methodologies. Costs reimbursed based on vouchers passing initial TED edits are subject to further payment adjustment by the Government if determined not to qualify as an allowable cost.

(d) Audit. At any time or times before final payment, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. "Audits" as used in this clause, includes audits on statistically valid samples. The audit results will be extrapolated across all the TRICARE medical claims for the region submitted for TED edits during the audited period to determine the total overpayment of the TRICARE medical claims population sampled for the region. The results of the audits will be used to adjust for overpayments of, or other unallowable health care costs. Underpayments made by the contractor that are found in an audit are not used to offset overpayment adjustments. These adjustments are in addition to the Government's rights under the Inspection of Services Clause (FAR 52.246-5). Any payment may be-

(1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs; or
(2) Adjusted for prior overpayments or underpayments.

(e) Final Payment.
(1) Upon approval of a completion invoice or voucher submitted by the Contractor, and upon the Contractor's compliance with all terms of this contract, the Government shall promptly pay any balance of allowable costs and that part of the fee (if any) not previously paid.

(2) The Contractor shall pay to the Government any refunds, rebates, credits, Contractor's claim overpayment or fraud recoveries, or other amounts (including interest, if any) accruing to or received by the contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government and not previously identified and returned to the Government as an unallowable cost. Before final payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver--

(i) An assignment to the Government, in form and substance satisfactory to the Contracting Officer, of refunds, rebates, credits, or other amounts (including interest, if any) properly allocable to costs for which the Contractor has been reimbursed by the Government under this contract; and

(ii) A release discharging the Government, its officers, agents, and employees from all liabilities, obligations, and claims arising out of or under this contract, except—

(A) Specified claims stated in exact amounts, or in estimated amounts when the exact amounts are not known;

(B) Claims (including reasonable incidental expenses) based upon liabilities of the Contractor to third parties arising out of the performance of this contract; provided, that the claims are not known to the contractor on the date of the execution of the release, and that the Contractor gives notice of the claims in writing to the Contracting Officer within 6 years following the release date or notice of final payment date, whichever is earlier.

(End of Clause)

52.216-8 Fixed Fee. (June 2011)
(CLINs 1003, 1004, 1006; CLINs 2003, 2004, 2006; CLINs 3003, 3004, 3006; CLINs 4003, 4004, 4006; CLINs 5003, 5004, 5006 and 9001.)

52.216-30 Time-and-Materials/Labor-Hour Proposal Requirements--Non-Commercial Item Acquisition without Adequate Price Competition. (FEB 2007)
CLINs 1015, 2015, 3015, 4015, and 5015.

(a) The Government contemplates award of a Time-and-Materials or Labor-Hour type of contract resulting from this solicitation.

(b) The offeror must specify separate fixed hourly rates in its offer that include wages, overhead, general and administrative expenses, and profit for each category of labor to be performed by--

(1) The offeror;

(2) Each subcontractor; and

(3) Each division, subsidiary, or affiliate of the offeror under a common control.

(c) Unless exempt under paragraph (d) of this provision, the fixed hourly rates for services transferred between divisions, subsidiaries, or affiliates of the offeror under a common control--

(1) Shall not include profit for the transferring organization; but

(2) May include profit for the prime Contractor.

(d) The fixed hourly rates for services that meet the definition of commercial item at 2.101 that are transferred between divisions, subsidiaries, or affiliates of the offeror under a common control may be the established catalog or market rate when it is the established practice of the transferring organization to price interorganizational transfers at other than cost for commercial work of the offeror or any division, subsidiary or affiliate of the offeror under a common control.

(End of provision)

52.217-8 Option to Extend Services. (NOV 1999)

The Government may require continued performance of any services within the limits and at the rates specified in the contract. These rates may be adjusted only as a result of revisions to prevailing labor rates provided by the Secretary of Labor. The option provision may be exercised more than once, but the total extension of performance hereunder shall not exceed 6 months. The Contracting Officer may exercise the option by written notice to the Contractor within 90 days of contract expiration.

(End of Clause)

52.217-9 Option to Extend the Term of the Contract. (MAR 2000)

(a) The Government may extend the term of this contract by written notice to the Contractor within 30 calendar days provided that the Government gives the Contractor a preliminary written notice of its intent to extend at least 60 days before the contract expires. The preliminary notice does not commit the Government to an extension.

(b) If the Government exercises this option, the extended contract shall be considered to include this option clause.

(c) The total duration of this contract, including the exercise of any options under this clause, shall not exceed 7 years, 5 months.

(End of clause)

52.219-4 Notice of Price Evaluation Preference for HUBZone Small Business Concerns. (JAN 2011)

52.219-8 Utilization of Small Business Concerns. (JAN 2011)

52.219-9 Small Business Subcontracting Plan. (JAN 2011)

52.219-9 Small Business Subcontracting Plan. - Alternate II (OCT 2001)

52.219-16 Liquidated Damages - Subcontracting Plan. (JAN 1999)

52.222-1 Notice to the Government of Labor Disputes. (FEB 1997)

52.222-2 Payment for Overtime Premiums. (JUL 1990)

(a) The use of overtime is authorized under this contract if the overtime premium does not exceed Zero (0) or the overtime premium is paid for work -

(1) Necessary to cope with emergencies such as those resulting from accidents, natural disasters, breakdowns of production equipment, or occasional production bottlenecks of a sporadic nature;

(2) By indirect-labor employees such as those performing duties in connection with administration, protection, transportation, maintenance, standby plant protection, operation of utilities, or accounting;

(3) To perform tests, industrial processes, laboratory procedures, loading or unloading of transportation conveyances, and operations in flight or afloat that are continuous in nature and cannot reasonably be interrupted or completed otherwise; or

(4) That will result in lower overall costs to the Government.

(b) Any request for estimated overtime premiums that exceeds the amount specified above shall include all estimated overtime for contract completion and shall -

(1) Identify the work unit; *e.g.*, department or section in which the requested overtime will be used, together with present workload, staffing, and other data of the affected unit sufficient to permit the Contracting Officer to evaluate the necessity for the overtime;

(2) Demonstrate the effect that denial of the request will have on the contract delivery or performance schedule;

(3) Identify the extent to which approval of overtime would affect the performance or payments in connection with other Government contracts, together with identification of each affected contract; and

(4) Provide reasons why the required work cannot be performed by using multishift operations or by employing additional personnel.

* Insert either "zero" or the dollar amount agreed to during negotiations. The inserted figure does not apply to the exceptions in subparagraph (a)(1) through (a)(4) of the clause.

(End of clause)

52.222-3 Convict Labor. (JUN 2003)

52.222-21 Prohibition of Segregated Facilities. (FEB 1999)

52.222-26 Equal Opportunity. (MAR 2007)

52.222-35 Equal Opportunity for Veterans (SEP 2010)

52.222-36 Affirmative Action for Workers with Disabilities. (OCT 2010)

52.222-37 Employment Reports on Veterans (SEP 2010)

52.222-40 Notification of Employee Rights Under the National Labor Relations Act (DEC 2010)

52.222-50 Combating Trafficking in Persons. (FEB 2009)

52.223-6 Drug-Free Workplace. (MAY 2001)

52.223-18 Encouraging Contractor Policies to Ban Text Messaging While Driving (AUG 2011)

52.224-1 Privacy Act Notification. (APR 1984)

52.224-2 Privacy Act. (APR 1984)

52.225-13 Restrictions on Certain Foreign Purchases. (JUN 2008)

52.227-1 Authorization and Consent. (DEC 2007)

52.227-2 Notice and Assistance Regarding Patent and Copyright Infringement. (DEC 2007)

52.227-3 Patent Indemnity. (APR 1984)

52.227-14 Rights in Data--General. (DEC 2007)

52.228-5 Insurance - Work on a Government Installation. (JAN 1997)

52.228-7 Insurance - Liability to Third Persons. (MAR 1996)

52.229-3 Federal, State, and Local Taxes. (APR 2003)

52.230-2 Cost Accounting Standards. (DEVIATION) (JAN 2012)

52.230-6 Administration of Cost Accounting Standards. (JUN 2010)

52.232-1 Payments. (APR 1984)

52.232-3 Payments under Personal Services Contracts. (APR 1984)
(CLINs/SubCLINs for Clinical Support Agreement when determined as a personal service)

52.232-7 Payments under Time-and-Materials and Labor-Hour Contracts. (FEB 2007)

52.232-8 Discounts for Prompt Payment. (FEB 2002)

52.232-9 Limitation on Withholding of Payments. (APR 1984)

52.232-11 Extras. (APR 1984)

52.232-17 Interest. (OCT 2010)

52.232-18 Availability of Funds. (APR 1984)

52.232-19 Availability of Funds for the Next Fiscal Year. (APR 1984)
Funds are not presently available for performance under this contract beyond 30 September 2012/2013/2014/2015/2016/2017 as applicable for option periods. The Government's obligation for performance of this contract beyond that date is contingent upon the availability of appropriated funds from which payment for contract purposes can be made. No legal liability on the part of the Government for any payment may arise for performance under this contract beyond 30 September 2012/2013/2014/2015/2016/2017 as applicable for option periods until funds are made available to the Contracting Officer for performance and until the Contractor receives notice of availability, to be confirmed in writing by the Contracting Officer.

(End of clause)

52.232-20 Limitation of Cost. (APR 1984)

52.232-22 Limitation of Funds. (APR 1984)

52.232-23 Assignment of Claims. (JAN 1986)

52.232-25 Prompt Payment. (OCT 2008)

52.232-25 Prompt payment. -- Alternate I (FEB 2002)

52.232-33 Payment by Electronic Funds Transfer - Central Contractor Registration. (OCT 2003)

52.232-37 Multiple Payment Arrangements. (MAY 1999)

52.233-1 Disputes. (JUL 2002)

52.233-1 Disputes. - Alternate I (DEC 1991)

52.233-3 Protest after Award. (AUG 1996)

52.233-3 Protest after Award. - Alternate I (JUN 1985)

52.233-4 Applicable Law for Breach of Contract Claim. (OCT 2004)

52.237-2 Protection of Government Buildings, Equipment, and Vegetation. (APR 1984)

52.237-3 Continuity of Services. (JAN 1991)

52.237-7 Indemnification and Medical Liability Insurance. (JAN 1997)
(Applies to any Non-Personal Services under CSA (CLINs 1014, 2014, 3014, 4014, 5014))

(a) It is expressly agreed and understood that this is a non-personal services contract, as defined in Federal Acquisition Regulation (FAR) 37.101, under which the professional services rendered by the Contractor are rendered in its capacity as an independent contractor. The Government may evaluate the quality of professional and administrative services provided, but retains no control over professional aspects of the services rendered, including by example, the Contractor's professional medical judgment, diagnosis, or specific medical treatments. The Contractor shall be solely liable for and expressly agrees to indemnify the Government with respect to any liability producing acts or omissions by it or by its employees or agents. The Contractor shall maintain during the term of this contract liability insurance issued by a responsible insurance carrier of not less than the following amount(s) per specialty per occurrence: As required in the state the military treatment facility is located, or the local community standard if none required by the state, or as specified by the contracting officer.

(b) An apparently successful offeror, upon request by the Contracting Officer, shall furnish prior to contract award evidence of its insurability concerning the medical liability insurance required by paragraph (a) of this clause.

(c) Liability insurance may be on either an occurrences basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term must also be provided.

(d) Evidence of insurance documenting the required coverage for each health care provider who will perform under this contract shall be provided to the Contracting Officer prior to the commencement of services under this contract. If the insurance is on a claims-made basis and evidence of an extended reporting endorsement is not provided prior to the commencement of services, evidence of such endorsement shall be provided to the Contracting Officer prior to the expiration of this contract. Final payment under this contract shall be withheld until evidence of the extended reporting endorsement is provided to the Contracting Officer.

(e) The policies evidencing required insurance shall also contain an endorsement to the effect that any cancellation or material change adversely affecting the Government's interest shall not be effective until 30 days after the insurer or the Contractor gives written notice to the Contracting Officer. If, during the performance period of the contract the Contractor changes insurance providers, the Contractor must provide evidence that the Government will be indemnified to the limits specified in paragraph (a) of this clause, for the entire period of the contract, either under the new policy, or a combination of old and new policies.

(f) The Contractor shall insert the substance of this clause, including this paragraph (f), in all subcontracts under this contract for health care services and shall require such subcontractors to provide evidence of and maintain insurance in accordance with paragraph (a) of this clause. At least 5 days before the commencement of work by any subcontractor, the Contractor shall furnish to the Contracting Officer evidence of such insurance.

(End of clause)

52.237-7 Indemnification and Medical Liability Insurance (JAN 1997) DEVIATION
(Excludes CSA SubCLINs/CLINs)

(a) The Contractor is responsible for determining the medical malpractice coverage required in the state (including state risk pools if applicable) for each network provider (both professional and institutional), and ensuring that each network provider is in compliance with this requirement. In the absence of state law requirement for medical malpractice insurance coverage, the Contractor is responsible for determining the local community standard for medical malpractice coverage, and the Contractor must maintain the documentation evidencing both the standard and compliance by network providers. In no case shall a network provider not have medical malpractice coverage.

(b) The Contractor shall be solely liable for and expressly agrees to indemnify the Government for the costs of defense and any liability resulting from services provided to Military Health System (MHS) eligible beneficiaries by a network provider. As an alternate, the Contractor shall have all network provider agreements used by the Contractor contain a requirement, directly or by reference, to applicable regulations or TRICARE Management Activity policies, that the provider agrees to indemnify, defend and hold harmless the Government from any and all claims, judgments, costs, liabilities, damages and expenses, including attorney's fees, whatsoever, arising from any acts or omissions in the provision of medical services by the provider to MHS eligible beneficiaries.

(c) Each network provider agreement must indicate the required malpractice coverage. Evidence documenting the required coverage of each network provider under the contract shall be provided to the Contracting Officer upon request. The Contracting Officer, after consulting with the Contractor, retains the authority to determine whether state and/or local community standards for medical malpractice coverage have been met by a network provider and whether the Contractor has documented the required coverage.

(d) Liability insurance may be on either an occurrences basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term must also be provided, or as long as standard practice in the locality or as may be required by local law or ordinance.

52.239-1 Privacy or Security Safeguards. (AUG 1996)

52.242-1 Notice of Intent to Disallow Costs. (APR 1984)

52.242-3 Penalties for Unallowable Costs. (MAY 2001)

52.242-4 Certification of Final Indirect Costs. (JAN 1997)

52.242-13 Bankruptcy. (JUL 1995)

52.243-1 Changes - Fixed-Price. (AUG 1987)

52.243-1 Changes - Fixed-Price. - Alternate I (APR 1984)

52.243-2 Changes - Cost-Reimbursement. (AUG 1987)

52.243-2 Changes - Cost-Reimbursement. - Alternate I (APR 1984)

52.243-3 Changes - Time-and-Materials or Labor-Hours. (SEP 2000)

52.243-6 Change Order Accounting. (APR 1984)

52.243-7 Notification of Changes. (APR 1984)

(a) *Definitions.* "Contracting Officer," as used in this clause, does not include any representative of the Contracting Officer.

"Specifically Authorized Representative (SAR)," as used in this clause, means any person the Contracting Officer has so designated by written notice (a copy of which shall be provided to the Contractor) which shall refer to this paragraph and shall be issued to the designated representative before the SAR exercises such authority.

(b) *Notice.* The primary purpose of this clause is to obtain prompt reporting of Government conduct that the Contractor considers to constitute a change to this contract. Except for changes identified as such in writing and signed by the Contracting Officer, the Contractor shall notify the Administrative Contracting Officer in writing promptly, within 30 calendar days from the date that the Contractor identifies any Government conduct (including actions, inactions, and written or oral communications) that the Contractor regards as a change to the contract terms and conditions. On the basis of the most accurate information available to the Contractor, the notice shall state -

(1) The date, nature, and circumstances of the conduct regarded as a change;

(2) The name, function, and activity of each Government individual and Contractor official or employee involved in or knowledgeable about such conduct;

(3) The identification of any documents and the substance of any oral communication involved in such conduct;

(4) In the instance of alleged acceleration of scheduled performance or delivery, the basis upon which it arose;

(5) The particular elements of contract performance for which the Contractor may seek an equitable adjustment under this clause, including -

(i) What contract line items have been or may be affected by the alleged change;

(ii) What labor or materials or both have been or may be added, deleted, or wasted by the alleged change;

(iii) To the extent practicable, what delay and disruption in the manner and sequence of performance and effect on continued performance have been or may be caused by the alleged change;

(iv) What adjustments to contract price, delivery schedule, and other provisions affected by the alleged change are estimated; and

(6) The Contractor's estimate of the time by which the Government must respond to the Contractor's notice to minimize cost, delay or disruption of performance.

(c) *Continued performance.* Following submission of the notice required by paragraph (b) of this clause, the Contractor shall diligently continue performance of this contract to the maximum extent possible in accordance with its terms and conditions as construed by the Contractor, unless the notice reports a direction of the Contracting Officer or a communication from a SAR of the Contracting Officer, in either of which events the Contractor shall continue performance; provided, however, that if the Contractor regards the direction or communication as a change as described in paragraph (b) of this clause, notice shall be given in the manner provided. All directions, communications, interpretations, orders and similar actions of the SAR shall be reduced to writing promptly and copies furnished to the Contractor and to the Contracting Officer. The Contracting Officer shall promptly countermand any action which exceeds the authority of the SAR.

(d) *Government response.* The Contracting Officer shall promptly, within 30 calendar days after receipt of notice, respond to the notice in writing. In responding, the Contracting Officer shall either -

(1) Confirm that the conduct of which the Contractor gave notice constitutes a change and when necessary direct the mode of further performance;

(2) Countermand any communication regarded as a change;

(3) Deny that the conduct of which the Contractor gave notice constitutes a change and when necessary direct the mode of further performance; or

(4) In the event the Contractor's notice information is inadequate to make a decision under paragraphs (d)(1), (2), or (3) of this clause, advise the Contractor what additional information is required, and establish the date by which it should be furnished and the date thereafter by which the Government will respond.

(e) *Equitable adjustments.* (1) If the Contracting Officer confirms that Government conduct effected a change as alleged by the Contractor, and the conduct causes an increase or decrease in the Contractor's cost of, or the time required for, performance of any part of the work under this contract, whether changed or not changed by such conduct, an equitable adjustment shall be made -

(i) In the contract price or delivery schedule or both; and

(ii) In such other provisions of the contract as may be affected.

(2) The contract shall be modified in writing accordingly. In the case of drawings, designs or specifications which are defective and for which the Government is responsible, the equitable adjustment shall include the cost and time extension for delay reasonably incurred by the Contractor in attempting to comply with the defective drawings, designs or specifications before the Contractor identified, or reasonably should have identified, such defect. When the cost of property made obsolete or excess as a result of a change confirmed by the Contracting Officer under this clause is included in the equitable adjustment, the Contracting Officer shall have the right to prescribe the manner of disposition of the property. The equitable adjustment shall not include increased costs or time extensions for delay resulting from the Contractor's failure to provide notice or to continue performance as provided, respectively, in paragraphs (b) and (c) of this clause.

Note: The phrases "contract price" and "cost" wherever they appear in the clause, may be appropriately modified to apply to cost-reimbursement or incentive contracts, or to combinations thereof.

(End of clause)

52.244-2 Subcontracts. (OCT 2010)

52.244-5 Competition in Subcontracting. (DEC 1996)

52.244-6 Subcontracts for Commercial Items. (DEC 2010)

52.245-1 Government Property. (AUG 2010)

52.245-1 Government Property. -- Alternate I (AUG 2010)

52.245-9 Use and Charges. (AUG 2010)

52.248-1 Value Engineering. (OCT 2010)

52.249-2 Termination for Convenience of the Government (Fixed-Price). (MAY 2004)

52.249-6 Termination (Cost-Reimbursement). (MAY 2004)

52.249-6 Termination (Cost-Reimbursement). - Alternate IV (SEP 1996)

52.249-8 Default (Fixed-Price Supply and Service). (APR 1984)

52.249-12 Termination (Personal Services). (APR 1984)
(CLINs/SubCLINs for Clinical Support Agreement when determined personal service)

52.249-14 Excusable Delays. (APR 1984)

52.252-6 Authorized Deviations in Clauses. (APR 1984)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the date of the clause.

(End of clause)

52.253-1 Computer Generated Forms. (JAN 1991)

252.201-7000 Contracting Officer's Representative. (DEC 1991)

(a) "Definition. Contracting officer's representative" means an individual designated in accordance with subsection 201.602-2 of the Defense Federal Acquisition Regulation Supplement and authorized in writing by the contracting officer to perform specific technical or administrative functions.

(b) If the Contracting Officer designates a contracting officer's representative (COR), the Contractor will receive a copy of the written designation. It will specify the extent of the COR's authority to act on behalf of the contracting officer. The COR is not authorized to make any commitments or changes that will affect price, quality, quantity, delivery, or any other term or condition of the contract.

(End of clause)

252.203-7000 Requirements Relating to Compensation of Former DoD Officials. (SEP 2011)

252.203-7001 Prohibition on persons convicted of fraud or other defense-contract-related felonies. (DEC 2008)

252.203-7002 Requirement to Inform Employees of Whistleblower Rights. (JAN 2009)

252.203-7003 Agency Office of the Inspector General (DEC 2011)

The agency office of the Inspector General referenced in paragraphs (c) and (d) of FAR clause 52.203-13, Contractor Code of Business Ethics and Conduct, is the DoD Office of the Inspector General at the following address:

DoD Office of the Inspector General
Investigative Policy and Oversight
400 Army Navy Drive, Suite 1037
Arlington, VA 22202-4704
Toll Free Telephone: 866-429-8011
(End of clause)

252.204-7000 Disclosure of Information. (DEC 1991)

252.204-7002 Payment for Subline Items Not Separately Priced. (DEC 1991)

252.204-7003 Control of Government Personnel Work Product. (APR 1992)

252.204-7004 Alternate A, Central Contractor Registration. (SEP 2007)

252.205-7000 Provision of Information to Cooperative Agreement Holders. (DEC 1991)

252.209-7004 Subcontracting with Firms That Are Owned or Controlled by the Government of a Terrorist Country. (DEC 2006)

252.215-7000 Pricing Adjustments. (DEC 1991)

252.215-7002 Cost Estimating System Requirements. (MAY 2011)

252.216-7004 Award Fee Reduction or Denial for Jeopardizing the Health or Safety of Government Personnel (SEP 2011)

252.216-7005 Award Fee (Feb 2011)

252.219-7003 Small Business Subcontracting Plan (DoD contracts). (SEP 2011)

252.219-7004 Small Business Subcontracting Plan (Test Program) (JAN 2011)

252.223-7004 Drug-Free Work Force. (SEP 1988)

252.225-7004 Report of Intended Performance Outside the United States and Canada--Submission after Award. (OCT 2010)

252.225-7006 Quarterly Reporting of Actual Contract Performance Outside the United States. (OCT 2010)

252.225-7012 Preference for Certain Domestic Commodities. (JUN 2010)

252.226-7001 Utilization of Indian Organizations, Indian-owned Economic Enterprises, and Native Hawaiian Small Business Concerns. (SEP 2004)

252.231-7000 Supplemental Cost Principles. (DEC 1991)

252.237-7010 Prohibition on Interrogation of Detainees by Contractor Personnel (Nov 2010)

252.242-7004 Material Management and Accounting System. (MAY 2011)

252.242-7005 Contractor Business Systems (MAY 2011)

252.242-7006 Accounting System Administration (MAY 2011)

252.243-7001 Pricing of Contract Modifications. (DEC 1991)

252.243-7002 Requests for Equitable Adjustment. (MAR 1998)

252.244-7001 Contractor Purchasing System Administration (MAY 2011)

SECTION J, LIST OF ATTACHMENTS AND EXHIBITS

SECTION J: LIST OF ATTACHMENTS

Attachment J-1	Government Required MTF Prime Service Areas
Attachment J-2	Government Required BRAC Site Prime Service Areas
Attachment J-3	Mandatory TSC Locations
Attachment J-4	CHAMPVA Fact Sheet 01-16 Dated Aug 06
Attachment J-5	Clinical Quality Incentive Performance Metrics
Attachment J-6	Hypothetical Example of the External Trend Incentive Calculation
Attachment J-7	Small Business Subcontracting Plan

LIST OF EXHIBITS

Exhibit A	Service Assist Teams – Time and Material Rates
Exhibit B	Contract Data Requirements List (DD Forms 1423-1) (SEE Section F.5., REPORTS AND PLANS for listing by frequency)

Section J Attachments

Attachment J-1
GOVERNMENT-REQUIRED MTF PRIME SERVICE AREAS

WEST REGION

Alaska	354th Medical Group-Eielson Air Force Base 3349 Central Ave. Eielson AFB, AK 99702	DMIS ID: 0203 Clinic
	3rd Medical Group-Elmendorf Air Force Base 5955 Zeamer Ave. Anchorage, AK 99506	DMIS ID: 0006 Hospital
	Bassett Army Community Hospital-Fort Wainwright 1060 Gaffney Rd., #7400 Ft. Wainwright, AK 99703	DMIS ID: 0005 Hospital
	US Coast Guard Clinic Bldg N46, Sarichef St. Kodiak, AK 99619	DMIS ID: 0130 Clinic
	US Coast Guard Clinic 1300 Stedman Street Ketchikan, AK 99901	DMIS ID: 0417 Clinic
	TMC Fort Richardson Bldg 604, 600 Richardson Dr. Ft. Richardson, AK 99505	DMIS ID: 0204 Clinic
	US Coast Guard Clinic 611 Airport Rd. Sitka, AK 99835	DMIS ID: 7047 Clinic
	US Coast Guard Clinic 709 West 9th Street, Ste 627 Juneau, AK 99802	DMIS ID: 7044 Clinic
Arizona	Branch Medical Clinic MCAS Bldg 1175, PO Box 99116 Yuma, AZ 85369	DMIS ID: 0269 Clinic
	355th Medical Group-Davis-Monthan Air Force Base 4175 S Alamo Ave Davis-Monthan, AZ 85707	DMIS ID: 0010 Clinic
	Raymond W. Bliss Army Health Center-Fort Huachuca 2240 E Winrow Ave. Fort Huachuca, AZ 85613	DMIS ID: 0008 Clinic
	56th Medical Group-Luke Air Force Base 7219 N Litchfield Rd. Luke AFB, AZ 85309	DMIS ID: 0009 Clinic
	US Army Health Clinic-Yuma Proving Ground 301 "C" Street, Bldg 990 Yuma YPG, AZ 85365	DMIS ID: 0206 Clinic
California	9th Medical Group-Beale Air Force Base 15301 Warren Shingle Road Beale AFB, CA 95903	DMIS ID: 0015 Clinic
	Branch Medical Clinic-Naval Air Facility El Centro Bldg 523 El Centro, CA 92243	DMIS ID: 0239 Clinic
	Naval Hospital Camp Pendleton Bldg H-100, Santa Margarita Rd Camp Pendleton, CA 92055	DMIS ID: 0024 Hospital
	95th Medical Group-Edwards Air Force Base 30 Nightingale Road, Bldg 5525 Edwards AFB, CA 93524	DMIS ID: 0019 Clinic
	Branch Medical Clinic-MCAS Miramar 19871 Bauer Rd San Diego, CA 92145	DMIS ID: 0232 Clinic

Attachment J-1
GOVERNMENT-REQUIRED MTF PRIME SERVICE AREAS

California - continued-	Weed Army Community Hospital-Fort Irwin 170 Interloop, Bldg. 170 Fort Irwin, CA 92310	DMIS ID: 0131 Hospital
	61st Medical Group-Los Angeles Air Force Base 483 N Aviation Blvd. El Segundo, CA 90245	DMIS ID: 0248 Clinic
	Naval Hospital Twentynine Palms 1145 Sturgis Rd. Twentynine Palms, CA 92278	DMIS ID: 0030 Hospital
	Branch Medical Clinic Barstow-Marine Corps Logistics Base 220 East Mountain View St., Ste A Barstow, CA 92311	DMIS ID: 0209 Clinic
	Naval Hospital Lemoore-Naval Air Station Lemoore 937 Franklin Ave Lemoore, CA 93246	DMIS ID: 0028 Hospital
	BMC Edson Range -31 Area Bldg 310514, Stuart Mesa Rd. Camp Pendleton, CA 92055	DMIS ID: 0210 Clinic
	BMC San Onofre – 52 Area Bldg 520450, Basilone Rd. Camp Pendleton, CA 92055	DMIS ID: 1659 Clinic
	Branch Medical Clinic-Naval Station North Island 601 McCain Blvd., Bldg 601 Coronado, CA 92135	DMIS ID: 0231 Clinic
	Naval Medical Center, San Diego-Balboa 34800 Bob Wilson Drive San Diego, CA 92134	DMIS ID: 0029 Hospital
	Branch Medical Clinic-Naval Weapon Station China Lake 1 Administration Circle, STOP 1311 Blandy China Lake, CA 93555	DMIS ID: 0212 Clinic
	Naval Ambulatory Care Center-Port Hueneme 162 First Street, Bldg 1402 Port Hueneme, CA 93043	DMIS ID: 0026 Clinic
	Army Health Clinic, Presidio-Monterey 473 Cabrillo St. Monterey, CA 93944	DMIS ID: 0247 Clinic
	David Grant Medical Center 60th Medical Group-Travis Air Force Base 101 Bodin Circle Fairfield, CA 94535	DMIS ID: 0014 Hospital
	30th Medical Group-Vandenberg Air Force Base 338 South Dakota Ave., Building 13850 Lompoc, CA 93437	DMIS ID: 0018 Clinic
	NBHC MCRD San Diego 35000 Guadalcanal Ave., Bldg 596 San Diego, CA 92140	DMIS ID: 0230 Clinic
	NBHC Coronado 3538 Bougainville Rd. Coronado, CA 92155	DMIS ID: 0233 Clinic
	NBHC NAVSTA San Diego Bldg 3300, 32nd St. Naval Base San Diego , CA 92136	DMIS ID: 0701 Clinic

Attachment J-1
GOVERNMENT-REQUIRED MTF PRIME SERVICE AREAS

California --continued--	US Coast Guard Clinic 1 Eagle Rd. Alameda, CA 94501	DMIS ID: 0418 Clinic
	US Coast Guard Clinic 599 Tomales Road Petaluma, CA 94952	DMIS ID: 0419 Clinic
	NBHC NTC San Diego 2650 Stockton Rd., Bldg 624 San Diego, CA 92106	DMIS ID: 0407 Clinic
	US Coast Guard Clinic 1001 S Seaside Ave., Bldg 23 San Pedro, CA 90731	DMIS ID: 7046 Clinic
	US Coast Guard Clinic 1001 Lycoming Way McKinleyville, CA 95521	DMIS ID: 7083 Clinic
	San Diego East County Primary Care Clinic 110-120 Town Center Parkway Santee, CA 92701	DMIS ID: 0409 Clinic
	TRICARE Outpatient Clinic – Oceanside 2122 El Camino Real, Ste 100 Oceanside, CA 92054	DMIS: 6216 Clinic
	TRICARE Outpatient Clinic – Clairemont 8808 Balboa Ave., Ste B San Diego, CA 92123	DMIS: 6207 Clinic
	TRICARE Outpatient Clinic – Chula Vista 644 Naples St. Chula Vista, CA 91911	DMIS: 6215 Clinic
Colorado	Evans Army Community Hospital-Fort Carson 1650 Cochrane Circle Ft. Carson, CO 80913	DMIS ID: 0032 Hospital
	Warrior Clinic – Fort Carson 6911 Titus Blvd., Bldg 2353 Ft Carson, CO 80913	DMIS ID: 7301 Clinic
	21st Medical Group-Peterson Air Force Base 559 Vincent Street Peterson AFB, CO 80914	DMIS ID: 0252 Clinic
	10th Medical Group-USAF Academy 4102 Pinion Dr. USAF Academy, CO 80840	DMIS ID: 0033 Hospital
	460th Med Group – Buckley AFB 275 S Aspen Street, STOP #89 Aurora, CO 80011	DMIS ID: 7200 Clinic
Hawaii	15th Medical Group-Hickam Air Force Base 755 Scott Circle Honolulu, HI 96853	DMIS ID: 0287 Clinic
	Branch Medical Clinic-Kaneohe Bay Marine Corps Base Bldg 3089, D Street Kaneohe, HI 96863	DMIS ID: 0285 Clinic

Attachment J-1
GOVERNMENT-REQUIRED MTF PRIME SERVICE AREAS

Hawaii - continued -	Naval Health Clinic –Hawaii 480 Central Ave. Pearl Harbor, HI 96860	DMIS ID: 0280 Clinic
	Tripler Army Medical Center 1 Jarrett White Road Honolulu, HI 96859	DMIS ID: 0052 Hospital
	NBHC NAVCAMS EASTPAC 500 Central Ave., Bldg 22 Wahiawa, HI 96786	DMIS ID: 0284 Clinic
	Army Health Clinic-Schofield Barracks Bldg 684, Waianae St. Schofield Barracks, HI 96857	DMIS ID: 0437 Clinic
	US Coast Guard Clinic 1 Jarrett White Road Honolulu, HI 96819	DMIS ID: 7043 Clinic
	NBHC MCB-Camp H.M. Smith Bldg. 3B Camp Smith, HI 96861	DMIS: 1987 Clinic
Idaho	366th Medical Group-Mountain Home Air Force Base 90 Hope Drive Mountain Home AFB, ID 83648	DMIS ID: 0053 Hospital
Kansas	Munson Army Health Center-Fort Leavenworth 550 Pope Ave. Fort Leavenworth, KS 66027	DMIS ID: 0058 Clinic
	Irwin Army Community Hospital-Fort Riley 600 Caisson Hill Rd. Ft. Riley, KS 66442	DMIS ID: 0057 Hospital
	Aviation Clinic – Fort Riley 814 Marshal Loop Ft Riley, KS 66442	DMIS: 1539
	Caldwell Clinic – Fort Riley 7665 Normandy Dr. Ft Riley, KS 66442	DMIS: 7337 Clinic
	22nd Medical Group-McConnell Air Force Base 57950 Leavenworth Street McConnell, KS 67221	DMIS ID: 0059 Clinic
Missouri	General Leonard Wood Army Community Hospital Fort Leonard Wood 126 Missouri Ave. Ft. Leonard Wood, MO 65473	DMIS ID: 0075 Hospital
	509th Medical Facility-Whiteman Air Force Base 331 Sijan Ave. Whiteman AFB, MO 65305	DMIS ID: 0076 Clinic
	Richards-Gebaur Clinic 15431 Andrews Rd. Kansas City, MO 64147	DMIS ID: 7297 Clinic
Montana	341st Medical Group-Malmstrom Air Force Base 7300 N Perimeter Rd. Malmstrom AFB, MT 59402	DMIS ID: 0077 Clinic
Nebraska	55th Medical Group – Ehrling Berquist Clinic Offutt Air Force Base 2501 Capehart Rd. Omaha, NE 68113	DMIS ID: 0078 Clinic

Attachment J-1
GOVERNMENT-REQUIRED MTF PRIME SERVICE AREAS

Nevada	Naval Branch Health Clinic-Naval Air Station Fallon 4755 Pasture Rd. Fallon, NV 89496	DMIS ID: 0319 Clinic
	Michael O'Callaghan Federal Hospital 99th Medical Group-Nellis Air Force Base 4700 North Las Vegas Blvd. Las Vegas, NV 89191	DMIS ID: 0079 Hospital
New Mexico	27th Medical Group-Cannon Air Force Base 208 W Casablanca Ave. Clovis, NM 88103	DMIS ID: 0085 Clinic
	49th Medical Group-Holloman Air Force Base 280 First Street, Bldg. 21 Holloman AFB, NM 88330	DMIS ID: 0084 Clinic
	377th Medical Group-Kirtland Air Force Base 2050A Second Street SE Albuquerque, NM 87117	DMIS ID: 0083 Clinic
	McAfee Army Health Clinic-White Sands Missile Range 530 Rock Island Rd. White Sands Missile Range, NM 88002	DMIS ID: 0327 Clinic
North Dakota	319th Medical Group-Grand Forks Air Force Base 1599 J Street Grand Forks, ND 58205	DMIS ID: 0093 Clinic
	5th Medical Group-Minot Air Force Base 10 Missile Dr. Minot, ND 58704	DMIS ID: 0094 Clinic
Oregon	US Coast Guard Clinic 2185 SE Airport Rd. Warrenton, OR 97146	DMIS ID: 0431 Clinic
	US Coast Guard Clinic 2000 Connecticut Ave. North Bend, OR 97459	DMIS ID: 7045 Clinic
South Dakota	28th Medical Group-Ellsworth Air Force Base 2900 Doolittle Dr. Rapid City, SD 57706	DMIS ID: 0106 Clinic
Texas	William Beaumont Army Medical Center-Fort Bliss 5005 N. Piedras Street, Bldg. 7777 El Paso, TX 79920	DMIS ID: 0108 Hospital
	Soldier Family Medical Clinic – Biggs 2496 Ricker Rd. El Paso, TX 79916	DMIS ID: 1481 Clinic
Utah	75th Medical Group-Hill Air Force Base 7321 11th Street, Bldg. 570 Ogden, UT 84056	DMIS ID: 0119 Clinic
Washington	92nd Medical Group-Fairchild Air Force Base 701 Hospital Loop Spokane, WA 99011	DMIS ID: 0128 Clinic
	Madigan Army Medical Center-Fort Lewis 9040 Fitzsimmons Dr. Tacoma, WA 98431	DMIS ID: 0125 Hospital
	Nisqually Family Medical Clinic Bldg R, 3134 3rd Division Rd & Camp Pendleton Ave Ft Lewis, WA 98433	DMIS ID: 1646 Clinic

Attachment J-1
GOVERNMENT-REQUIRED MTF PRIME SERVICE AREAS

Washington --continued--	Okubo Family Practice Clinic 17th & C Street North Ft Lewis, WA 98433	DMIS ID: 1649 Clinic
	62nd Medical Group-McChord Air Force Base 690 Barnes Blvd. McChord AFB, WA 98438	DMIS ID: 0395 Clinic
	Naval Hospital Oak Harbor 3475 North Saratoga St. Oak Harbor, WA 98278	DMIS ID: 0127 Hospital
	Naval Hospital Bremerton 1 Boone Rd. Bremerton, WA 98312	DMIS ID: 0126 Hospital
	NBHC Subase Bangor 2050 Barb St, Suite A Silverdale, WA 98315	DMIS ID: 1656
	US Coast Guard Clinic Ediz Hook Rd. Port Angeles, WA 98362	DMIS ID: 0434 Clinic
	US Coast Guard Clinic 1519 Alaskan Way South Seattle, WA 98134	DMIS ID: 0435 Clinic
	NBHC Everett 2000 W Marine View Dr. Everett, WA 98207	DMIS ID: 7138 Clinic
Wyoming	90th Medical Group-Francis E. Warren Air Force Base 6900 Alden Dr. FE Warren AFB, WY 82005	DMIS ID: 0129 Clinic

Attachment J-2

GOVERNMENT REQUIRED BRAC SITE PRIME SERVICE AREAS

WEST REGION BRAC SITES

STATE	FORMER FACILITY	FACILITY CITY/STATE	ZIP CODE	DMIS
Arizona	Williams Air Force Base	Mesa, AZ	85224	0011
California	Sierra Army Depot	Herlong, CA	96113	0244
	NMCL Long Beach	Long Beach, CA	90822	0025
	BMC El Toro	El Toro, CA	92706	0510
	March Air Force Base	Riverside, CA	92518	0021
	Norton Air Force Base	San Bernadino, CA	92409	0249
	George Air Force Base	Victorville, CA	92392	0020
	Fort Hunter-Liggett Army Health Clinic	Jolan, CA	93928	0246
	Castle Air Force Base	Merced, CA	95342	0017
	Fort Ord	Ft. Ord, CA	93941	0023
	Presidio of San Francisco	San Francisco, CA	94129	0022
	NH Oakland	Oakland, CA	94627	0027
	BMC NAS Alameda	Alameda, CA	94501	0220
	Onizuka AS	Sunnyvale, CA	94089	0235
	NMCL San Francisco	San Francisco, CA	94130	0411
	Sacramento Army Depot	Sacramento, CA	95813	0242
	BMC NSC Mare Island	Oakland, CA	94592	0221
Colorado	Fitzsimons Army Medical Center	Aurora, CO	80045	0031
Washington	NBHC Puget Sound	Bremerton, WA	98314	0398

Attachment J-3

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMIS ID	On Gov't Inst. (Y/N)	In MTF (Y/N)	Location	Sq Ft.	Hours of Operation
ALASKA MARKET						
Bassett ACH, Fort Wainwright AK	0005	Y	Y	4076 Neely Road, Bldg. 4076, Room 1F-102 & 1F-102A Ft Wainwright, AK 99703	176 with 120 Shared Waiting Area	0730-1600
3rd Medical Group, Elmendorf AFB AK	0006	Y	Y	5955 Zeamer Avenue, Room 2D107, 2D109 and 2D166 Elmendorf AFB, AK 99506-3707	505	0730-1600
USCG - Kodiak AK	0130	Y	Y	USCG Rockmore - King Clinic Bldg N-46 Kodiak, AK 99619-5000	191	0730-1600
354th Medical Group, Eielson AFB AK	0203	Y	Y	2630 Central Avenue, Room G01 Eielson AFB, AK 99702	at least 150 square feet with the current square footage of 231	0730-1630
Welcome Center, Ft. Richardson AK	0204	Y	N	Richardson Drive Building 600, Room 125A Ft. Richardson, AK 99505	110	0730-1630
USCG - Ketchikan AK	0417	Y	Y	1300 Stedman Street Ketchikan, AK 99901	132	0730-1545
USCG - Juneau AK	7044	Y	Y	709 9th Street, Suite 621A Juneau, AK 99802-5517	100	0730-1600
USCG - Sitka AK	7047	Y	Y	TSC - Commanding Officer US Coast Guard Air Station 611 Airport RD Sitka, AK 99835-6500	400 include waiting area outside office	0800-1600
CENTRAL MARKET						
Evans ACH Ft. Carson CO	0032	Y	Y	1650 Cochrane Circle Building 7500 Suite 2064 Ft. Carson, CO 80913-4604	1,250	0730-1615
Welcome Center, Ft. Carson CO	0032	Y	N	1625 Ellis Street, Building 1219 Ft. Carson, CO 80913	200	0730-1615
10th Medical Group - USAF Academy CO	0033	Y	Y	4102 Pinion Drive Building 4102 - Room 1N10 Colorado Springs, CO 80918	472	0730-1600

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMI S ID	On Gov't Inst. (Y/N)	In MTF (Y/N)	Location	Sq Ft.	Hours of Operation
Irwin ACH Ft. Riley KS	0057	Y	Y	600 Caisson Hill Road, Building 600 Ft Riley KS 66442-5037	1,200	0730-1630
Welcome Center, Ft. Riley KS	0057	Y	N	138 Custer Avenue, Bldg 210, Rm 56 Ft Riley KS 66442-5037	280	Variable
Munson AHC Ft. Leavenworth KS	0058	Y	Y	550 Pope Avenue, Building 343 Ft Leavenworth, KS 66027	700	0730-1630
22nd Medical Group,	0059	Y	Y	57950 Leavenworth Avenue, Bldg. 250	400	0730-1630
Leonard Wood ACH Ft. Leonard Wood MO	0075	Y	Y	310 Freedom Drive, Building 310 FT Leonard Wood, MO 65476	1,148	0700-1600
Welcome Center, Ft. Leonard Wood MO	0075	Y	N	140 Replacement Avenue, Building 470 FT Leonard Wood, MO 65476	220	0700-1600
509th Medical Group, Whiteman AFB MO	0076	Y	Y	331 Sijan Avenue Whiteman AFB MO 65305-5001	377	0730-1630
55th Medical Group, Offutt AFB NE	0078	Y	Y	2501 Capehart Road, Offutt AFB NE 68113-2160	1,228	0730-1630
319th Medical Group, Grand Forks AFB ND	0093	Y	N	1599 J Street, Building 109, Room 610 Grand Forks AFB, ND 58205-6332	Min. 659	0730-1600
5th Medical Group, Minot AFB ND	0094	Y	Y	10 Missile Avenue, Minot AFB, ND 58705	879.7	0730-1630
28th Medical Group, Ellsworth AFB SD	0106	Y	Y	2900 Doolittle Drive, Building 6000 Ellsworth AFB, SD 57706-4821	537 + sharing storage room	0730-1630
90th Medical Group, F.E. Warren AFB WY	0129	Y	Y	6900 Alden Dive, Building 160 F.E. Warren AFB, WY 82005-3913	671	0730-1630
21st Medical Group, Peterson AFB CO	0252	Y	Y	559 Vincent Street, Building 959 Peterson AFB, CO 80914-1540	788	0730-1630
460 Medical Group,	7200	N	N		1,337	
Richard - Gebaur, TRICARE Clinic MO	7297	N	N		Off Base	
HAWAII MARKET						
Tripler AMC HI	0052	Y	Y	1 Jarrett White Road Building 1 Room 1C005 (MCHK-MC) Tripler AMC, HI 96859-5000	849	0730-1630
NMCL Pearl Harbor (Makalapa) HI	0280	Y	Y	BHC Hawaii Bldg. 1514 Makalapa Avenue, Pearl Harbor, HI 96860	196	0730-1630
15th Medical Group, Hickam AFB HI	0287	Y	Y	TSC - Hickam AFB 755 Scott Circle, Building 559, A-Wing Hickam AFB, HI 96853	133.5	0730-1630

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMIS ID	On Gov't Inst. (Y/N)	In MTF (Y/N)	Location	Sq Ft.	Hours of Operation
BMC, MCAS Kaneohe Bay - located on D St. on MCAS Kaneohe Bay HI	0285	Y	Y	Marine Corp Base Hawaii Naval Branch Medical Clinic BLDG 3089, A-Pod, Rm 318, 320 Kaneohe Baby, HI 96863-3066	90	0730-1630
Schofield Barracks AHC HI	0437	Y	Y	USAHC - Building 676, Room 217 Schofield Barracks, HI 96857-5460	252	0730-1630
MOUNTAIN MARKET						
RW Bliss AHC Ft. Huachuca AZ	0008	Y	Y	RWBAHC, Bldg 45001 2240 Winroe Ave Ft Huachuca, AZ 85613-7049	474 + 168 shared waiting area	0730-1630
56th Medical Group	0009	Y	Y	7219 N. Litchfield Road, Bldg 1130	826 +	0730-1630
355th Medical Group, Davis Monthan AFB AZ	0010	Y	Y	4175 S. Alamo Ave, Bldg. 400 Rm. 206 Davis-Monthan AFB, AZ 85707-4405	1,472	0730-1630
366th Medical Group, Mountain Home AFB ID	0053	Y	Y	90 Hope Drive, Building 6000, Room F-113 Mountain Home AFB, ID 83648-1000	1,032 include shared waiting area	0730-1630
341st Medical Group, Malmstrom AFB MT	0077	Y	Y	7300 N. Perimeter Road, Building 2040 Malmstrom AFB, MT 59402-6780	1,061	0730-1630
377th Medical Group, Kirtland AFB NM	0083	Y	Y	1501 San Pedro SE Bldg 47 Albuquerque, NM 87107	802	0700-1600
49th Medical Group, Holloman AFB NM	0084	Y	Y	280 First Street, Building 15 Holloman AFB, NM 88330-8273	621	0730-1630
27th Medical Group, Cannon AFB NM	0085	Y	Y	208 W. Casablanca Avenue, Bldg. 1400 Cannon AFB, NM 88103-5014	734	0730-1630
William Beaumont AMC, Fort Bliss TX	0108	Y	Y	5005 North Piedras Street Bldg 7777; 1st Floor; Room 1192 El Paso, TX 79920-5001	1786 + shared waiting area	0730-1630
75th Medical Group, Hill AFB UT	0119	Y	Y	7321 Balmer Street, Bldg 570 Hill AFB, UT 84056-5012	1,213	0730-1630
McAfee AHC White Sands Missile Range NM	0327	Y	N	TCAC - 530 Rock Island Avenue Building 530, Room 303 & 306 WSMR, NM 88002-5520	465	Variable
Welcome Center, Ft. Bliss TX	1617	Y	N	TCAC - 505 Pershing Rd Bldg 505, Room 106 Fort Bliss, TX 79920	416	0800-1630

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMIS ID	On Gov't Inst. (Y/N)	In MTF (Y/N)	Location	Sq Ft.	Hours of Operation
NORTHWEST MARKET						
Madigan AMC, Fort Lewis WA	0125	Y	Y	9040A Reid Street, Rm. 2-56-33A Tacoma, WA 98431-1100	1,795	0700-1700
Welcome Center - Waller Hall, Fort Lewis WA	0125	Y	N	Waller Hall Tricare Service Center Bldg 2140, Rm 204 Fort Lewis, WA 98433	500 include shared waiting area	0700-1700
Yakima Training Center	N/A	Y	N	970 Firing Center, Bldg. 221 Yakima, WA 98901	209	0730-1600
NH Bremerton WA	0126	Y	N	1 Boone Road - Code 084-HP01 Bldg.HP-17, 3rd Deck, Rooms 3308, 3309, 3310, 3311, 3311A, 3313 and the reception area in the lobby (3304A) in front of the TSC Bremerton, WA 98312-1898	672	0730-1630
NH Oak Harbor WA	0127	Y	Y	3475 N. Saratoga St. Rms. 313, 315, & 316 1st Fl. of Hospital Oak Harbor, WA 98278-8800	350	0700-1700
92nd Medical Group, Fairchild AFB WA	0128	Y	Y	701 Hospital Loop, Suite 107A Fairchild AFB, Washington 99011-8701	822	0730-1630
62nd Medical Group, McChord AFB WA	0395	Y	Y	TRICARE Service Center 690 Barnes Boulevard McChord AFB, WA 98438	544 + shared waiting area	0730-1630
USCG - Astoria OR	0431	Y	Y	TSC - Commanding Officer US Coast Guard Air Station 2185 SE 12th Place Warrenton Or. 97146-9693	140	0730-1600
USCG - Port Angeles WA	0434	Y	Y	TSC - Commanding Officer US Coast Guard Air Station Port Angeles, WA. 98362	192	0800-1600
USCG - Seattle WA	0435	Y	Y	TSC - Commanding Officer U. S. Coast Guard ISC 1519 Alaskan Way South Seattle, WA 98314-1192	224	0700-1530
USCG - North Bend OR	7045	Y	Y		Contract or leased space	
BMC NAS Everett WA	7138	Y	N	2000 W. Marine View Drive, Bldg. 2010 Everett WA. 98207	200	0730-1630

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMIS ID	On Gov't Inst. (Y/N)	In MTF (Y/N)	Location	Sq Ft.	Hours of Operation
SOUTHWEST MARKET						
60th Medical Group, Travis AFB CA	0014	Y	Y	David Grant Medical Center 101 Bodin Circle, Bldg. 777 Travis AFB, CA 94535	1,112	0730-1700
9th Medical Group,	0015	Y	Y	15301 Warren Shingle Road, Bldg. 5700	370	0730-1630
BMC - Naval Air Facility, El Centro, CA	0239	Y	Y	Naval Air Facility, Bldg. 523 El Centro, CA 92243	New TSC	New TSC
30th Medical Group, Vandenberg AFB CA	0018	Y	N	338 South Dakota Ave, Bldg. 13850 Vandenberg AFB, CA 93437	531	0730-1700
95th Medical Group, Edwards AFB CA	0019	Y	N	30 Nightingale Road Building 5525, Room A2012 Edwards AFB CA 93524-1730	500	0730-1630
NH Camp Pendleton CA	0024	Y	Y	Box 555191, Building H-100, 6-South Camp Pendleton, CA 92055-5191	1,100	0700-1700
NH Camp Pendleton JRC	0024	Y	N	TSC - Joint Reception Center Bldg 130132 Camp Pendleton, CA 92055	100 - Space provided by MCB Camp Pendleton	0700-1700
NACC Port Hueneme CA	0026	Y	N		Contract or owned Temp bldg.	
NH NAS Lemoore CA	0028	Y	Y	937 Franklin Avenue 1st Deck, Bldg 937, West End Occupy Rooms 1497, 1494, 1495 Share Rooms 1496, 1416, 1006 for stroage and IM/IT Equipment 1st Deck, Bldg 937, West End NAS Lemoore CA 93246-5004	656.59	0730-1700
NMC San Diego CA	0029	Y	N	34800 Bob Wilson Drive, Building 2-1 San Diego, CA 92134	1,600	0730-1730
NH MCAGCC 29 Palms CA	0030	Y	Y	Bldg 1145 Sturgis Avenue On Base, 1st Floor, 1st Clinic Area Twentynine Palms, CA 92288	450	0700-1700

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMIS ID	On Gov't Inst. (Y/N)	In MTF (Y/N)	Location	Sq Ft	Hours of Operation
99th Medical Group, Nellis AFB NV	0079	Y	Y	Physical Address: Mike O'Callaghan Federal Hospital 4700 North Las Vegas Blvd., 1st Fl. Nellis AFB NV 89191-6601 Mailing Address: 4375 Las Vegas Blvd. North Suit 9 Las Vegas, NV 89115	1,225	0730-1630
Weed ACH Ft. Irwin CA	0131	Y	N	TSC - USA MEDDAC P.O. Box 105109 Building 170, Inner Loop Street, Rm 402 Ft. Irwin, CA 92310-5109	850 include shared waiting area	0730-1630
BMC China Lake CA	0212	Y	Y	1 Administration Circle, Stop 1311, On Base, 1st Floor, NE Corner China Lake, CA, 93555	218	0730-1630
BMC MCAS Miramar, San Diego, CA	0232	Y	N	MCAS Miramar, Bldg. 2496 PO Box 452002 San Diego, CA 92145-2002	206	0730-1730
Miramar JRC	0232	Y	N	Bldg #2258, Mitscher Way, 92143	163	0730-1730
NAS San Diego CA	0234	Y	N	Naval Station, Bldg. 270 3115 Dolphin Alley San Diego, CA 92136-5599	589	0730-1730
CA Medical Detachment Presidio of Monterey CA	0247	Y	N	4260 Giggling Road Fort Ord Military Community Seaside, CA 93955	1,400	0800-1630
61st MDSS, Los Angeles AFB CA	0248	Y	N	348 Orbital Loop Bldg 272, Room C2-318 El Segundo, CA 90245-4659	1,232	0700-1600
BMC MCAS Yuma CA	0269	Y	N		Contract or owned Temp bldg.	
BMC NAS Fallon NV	0319	Y	N	TSC - Branch Medical Clinic 4755 Pasture Road Naval Air Station, Building. 324 Fallon, NV 89406	360	0730-1630
BMC NTC San Diego CA	0407	Y	N	TSC - Branch Medical Clinic Naval Training Center 2650 Stockton Road, Bldg. 624 San Diego, CA 92106-6000	288	Variable

MANDATORY TRICARE Service Center Locations - West Region

MTF Name	DMIS ID	Gov't Inst. (Y/N)	On MTF (Y/N)	Location	Sq Ft.	Hours of Operation
USCG - Alameda CA	0418	Y	Y	TSC - Commanding Officer U. S. Coast Guard ISC Medical Clinic Bldg 1 Coast Guard Island Alameda, CA 94501	302	0700-1500
USCG - Petaluma CA	0419	Y	Y	US Coast Guard TRACEN 599 Tomales Road Rooms 111 and 112 Petaluma, CA 94952-5000	235 + shared waiting area	0700-1530
USCG - Humboldt Bay CA	7083	Y	Y	TSC - Commander 1001 Lycoming Way, USCG Air Station Humboldt Bay McKinleyville, CA 95519-9309	292	0800-1600
USCG - San Pedro CA	7046	Y	Y	TSC - Commanding Officer U. S. Coast Guard ISC 1001 S. Seaside Avenue San Pedro, CA 90731	90 + shared waiting area	0700-1530

Department of Veterans Affairs
Health Administration Center
CHAMPVA

FACT SHEET 01-16
For Outpatient Providers and Office Managers

What is CHAMPVA?

CHAMPVA is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of certain health care services and supplies with eligible beneficiaries (see Eligibility Fact Sheet 01-03 for criteria for CHAMPVA coverage). CHAMPVA is managed by the VA's Health Administration Center (HAC) in Denver, Colorado. We process CHAMPVA applications, determine eligibility, authorize benefits, and process medical claims.

How does CHAMPVA relate to TRICARE?

Both are federal programs, however, an individual who is eligible for TRICARE is not eligible for CHAMPVA. Although similar, TRICARE (formerly CHAMPUS - which is administered by the Department of Defense) should not be confused with CHAMPVA. TRICARE provides coverage to the families of active duty service members, families of service members who died while on active duty, and retirees and their families, whether or not the veteran is disabled.

Is preauthorization required for services?

Certain types of care/services require advance approval commonly known as preauthorization. This approval or preauthorization is extremely important and the failure to obtain it may result in denial of the claim. Preauthorization is required for:

- Dental care
- Durable medical equipment with a purchase price or total rental price of $300 or more
- Hospice services
- Mental health/substance abuse services (see Mental Health and Substance Use Disorder Benefits Fact Sheet 01-01)
- Transplants

Do I need approvals for referrals to specialists or for diagnostic tests?

No, as long as they are medically necessary.

Are case management and utilization reviews performed?

Yes, clinical claims reviews are performed for a variety of medical services including physical, occupational and speech therapy, home health, skilled nursing, rehabilitation, and utilization of controlled substances. Simply submit the medical documentation along with your claim. Utilization reviews are also performed for services requiring preauthorization.

Is there a contract or agreement that I must sign to accept/participate in CHAMPVA?

No. CHAMPVA does not have contract providers. You must be properly licensed in your state to receive payment from CHAMPVA and cannot be on the Medicare exclusion list.

Do I have to accept the CHAMPVA allowable rate?

Yes, under 38 CFR section 17.272(b) (3) and (4), providers must accept the CHAMPVA allowable rate and cannot balance bill the beneficiary.

How do I get a claim paid?

The HCFA-1500 should be sent to:

VA Health Administration Center
CHAMPVA
PO Box 65024
Denver, CO 80206-9024

This is the only address that should be used for CHAMPVA claim submissions.

If the beneficiary has other health insurance (OHI), they should be billed first. The explanation of benefits (EOB) from the OHI should then be submitted with the claim for reimbursement to CHAMPVA. By law, CHAMPVA is always secondary payer except to Medicaid, State Victims of Crime Compensation Programs, and supplemental CHAMPVA policies.

What does CHAMPVA pay?

In most cases, CHAMPVA pays equivalent to Medicare/TRICARE rates. CHAMPVA has an outpatient deductible ($50 per person up to $100 per family per calendar year) and a cost share of 25%. You should collect the 25% allowable cost share from the patient except when the patient has other health insurance.

If the beneficiary has other health insurance, then CHAMPVA pays the lessor of either 75% of the allowable amount after $50 calendar year deductible is satisfied, or the remainder of the charges and the beneficiary will normally have no cost share.

How fast does CHAMPVA pay?

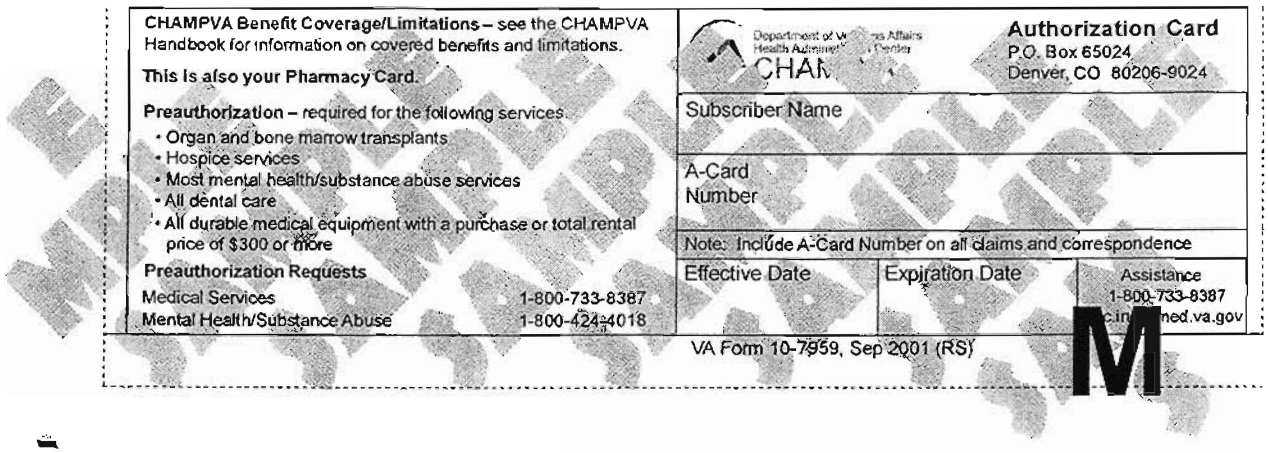
CHAMPVA normally pays 95% of claims within 30 days.

Are there special considerations for Ambulatory Surgery Centers?

Yes, they must have Medicare approval to perform the specific procedure at free-standing surgical centers.

How do I know if someone is CHAMPVA eligible?

Every CHAMPVA beneficiary has a CHAMPVA member card that looks like this:


CHAMPVA Benefit Coverage/Limitations – see the CHAMPVA Handbook for information on covered benefits and limitations.

This is also your Pharmacy Card.

Preauthorization – required for the following services.
- Organ and bone marrow transplants
- Hospice services
- Most mental health/substance abuse services
- All dental care
- All durable medical equipment with a purchase or total rental price of $300 or more

Preauthorization Requests

Medical Services	1-800-733-8387
Mental Health/Substance Abuse	1-800-424-4018

Authorization Card
P.O. Box 65024
Denver, CO 80206-9024

Subscriber Name

A-Card Number

Note: Include A-Card Number on all claims and correspondence

Effective Date	Expiration Date	Assistance
		1-800-733-8387

VA Form 10-7959, Sep 2001 (RS)

How do I get more information?

- Mail: VA Health Administration Center
  CHAMPVA
  PO Box 65023
  Denver, CO 80206-9023
- Phone: 1-800-733-8387
  Monday–Friday 8:05 a.m.–7:30 p.m. Eastern Time
- FAX: 1-303-331-7804
- Email: **hac.inq@va.gov**
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CLINICAL QUALITY INCENTIVE – PERFORMANCE METRICS

Performance Metric: **Cancer Screening – Cervical**

Description: Percentage of women continuously enrolled as Prime to the TRICARE Network, age 21-64 years who have received one or more Pap tests to screen for cervical cancer.

Rationale: Cervical cancer can be detected in its early stages by regular screening using a Pap test. The number of organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 21. (HEDIS)

Type of Measure: Process

Improvement Noted As: An increase in the rate

Calculation:

Numerator Statement: Number of women continuously enrolled as Prime to the TRICARE Network, age 24-64, with coded cervical cancer screening at least once in the past three years.

Denominator Statement: Number of women enrollees as of the last day of the measurement month, age 21-64, which were continuously enrolled during the preceding 36-month period without a documented hysterectomy. A woman whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

Performance measures require a retrospective approach. Women are not included in the denominator for this measure until age 24 (3-year look back).

Risk Adjustment: No

Measure Analysis Suggestions:
- Review of the denominator population and the level of metric compliance allows for workload projections based on enrolled population.

Data Sources:
- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)
- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- CHCS Laboratory and Pathology

Reporting Frequency: Data are reported at the beginning and end of each option period.

Performance Metric: **Cancer Screening – Breast**

Description: Percentage of women enrolled as Prime to the TRICARE Network, age 42-69, who had a mammogram in the previous 24 months.

Rationale: Breast cancer is the second the most common type of cancer among American women, with over 190,000 new cases reported each year. It is most common in women over 50. Mammography screening has been shown to reduce mortality by 20% to 30% among women 40 and older. A mammogram is an x-ray of the breast that can reveal tumors too small to be felt by hand. The U.S. Preventive Services Task Force, the American Academy of Family Physicians and the American College of Preventative Medicine recommend mammograms at the most effective method for detecting breast cancer when it is most treatable. (HEDIS)

Type of Measure: Process

Improvement Noted As: An increase in the rate

Calculation:

Numerator Statement: Number of women continuously enrolled to the TRICARE Network, age 42-69, who had one or more mammograms in the previous 24 months. Report two age stratifications and the overall rate.

- 42-51 years
- 52-69 years
- Total

Denominator Statement: Number of women enrollees as of the last day of the measurement month, age 42-69, who were continuously enrolled the preceding 24-month period. A woman whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

Patients with bilateral surgical mastectomy codes were excluded.

Data Sources:

- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)
- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- CHCS Radiology

Reporting Frequency: Data are reported at the beginning and end of each option period.

Performance Metric: Asthma - Use of Appropriate Medications

Metric Description: Patients with persistent asthma, ages 5-56, who are prescribed medications considered acceptable as a primary therapy for the long-term control of asthma.

Background:
The MHSPHP methodology is based on 2007 HEDIS® criteria. These are a set of criteria used to benchmark treatment facilities using a common methodology and should not be confused with clinical practice guidelines. This process measure evaluates if enrollees with persistent asthma are prescribed medications for long-term asthma control. In order to obtain information based on administrative sources, the term "persistent" asthma is based on two years of services and/or medication use rather than the clinical measurement of severity. The "action report" provided to treatment facilities on the MHSPHP includes asthmatics regardless of age or continuous enrollment.

Calculation:

Numerator: Number of patients with persistent asthma enrolled as Prime to the TRICARE Network, ages 5-56, who are prescribed medications considered acceptable as a primary therapy for the long-term control of asthma.

Members must have at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines within the last year. Long acting inhaled beta-2 agonists do not count in the numerator because they are recommended as an add-on rather than a primary therapy for persistent asthma.

Denominator: Number of Prime TRICARE Network enrollees, ages 5-56, continuously enrolled for the last two years, who were identified as having persistent asthma. Persistent asthma is defined by meeting at least one of the four criteria listed below, during BOTH the last 12 months (measurement year) and the year prior to the measurement year. The criteria met do not need to be the same across years.

1. At least four medication dispensing events of the following medications: inhaled corticosteroids, cromolyn sodium and nedocromil, methylxanthines, long-acting inhaled beta-2 agonist (except terbutaline) or leukotriene modifiers (when leukotriene modifiers were the sole asthma medication dispensed, the member must also meet any one of the other three criteria or have at least one diagnosis of asthma in any setting). A dispensing event is one prescription of an amount lasting 30 days or less. Two different prescriptions dispensed on the same day are counted as two different dispensing events. However, multiple inhalers of the same medication filled on the same date of service will be counted as one dispensing event. To calculate dispensing events for prescriptions longer than 30 days, the days' supply was divided by 30 and rounded up.
2. At least one Emergency Department (ED) visit with asthma as the principal diagnosis.
3. At least one acute inpatient discharge with asthma as the principle diagnosis.
4. At least four outpatient asthma visits with asthma as one of the listed diagnoses and at least two asthma medications dispensing events.

Patients with diagnosis codes for emphysema or COPD were excluded.

Risk Adjustment: No

Measure Analysis Suggestions:

- Review chronic disease burden data to project provision of health care services.

Data Sources:

- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)

- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- Pharmacy Data Transcription Service (PDTS) (M2)

Reporting Frequency: Data are reported at the beginning and end of each option period.

Performance Metric: **Cancer Screening – Colorectal**

Description: Percentage of adults enrolled as Prime to the TRICARE Network, age 51-80, who have had appropriate colorectal cancer screening. Screening intervals vary according to the method of screening.

Rationale: Colorectal cancer is the second-leading cause of cancer related deaths in the United States. Unlike other screening test that only detect disease, some methods of colorectal cancer screening can detect pre-malignant polyps and guide the removal which in theory can prevent to the development of cancer. (HEDIS)

Type of Measure: Process

Improvement Noted As: An increase in the rate

Calculation:

Numerator Statement: Number of adults continuously enrolled as Prime to the TRICARE Network, age 51-80 years who had appropriate colorectal cancer screening. Screening intervals vary according to the method of screening.

One or more screenings for Colorectal Cancer Screening. Appropriate screening must meet one of four criteria:

- Fecal Occult Blood Test (FOBT) within the last 12 months
- Flexible Sigmoidoscopy within the last 60 months
- Double Contrast Barium Enema (DCBE) within the last 60 months
- Colonoscopy within the last 120 months

Denominator Statement: Number of adult enrollees as of the last day of the measurement month, age 51-80, who were continuously enrolled according to DEERS during the preceding 24-month period. An adult whose coverage lapses for more than two months (60 days) during each previous 12-month period of enrollment is not considered continuously enrolled.

Patients with a diagnosis of colorectal cancer or with a previous total colectomy were excluded (see exclusion codes below under "Data Sources & Codes"). Performance measures require a retrospective approach; adults are not included in the denominator for this measure until age 51 (1-year look back).

Risk Adjustment: No

Measure Analysis Suggestions:
- Review of the denominator population and the level of metric compliance allows for workload projections based on enrolled population.

Data Sources:
- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)
- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- CHCS Laboratory
- Radiology (M2)

Reporting Frequency: Data are reported at the beginning and end of each option period.

Performance Metric: **Diabetes Care – A1c Test**

Description: Percent of patients enrolled as Prime in the TRICARE Network with Type 1 or Type 2 diabetes, age 18-75, who had their most recent A1c performed sometime during the past year.

Rationale: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 17 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20% of all tests and persons over 25. Many complications, such as imputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Calculation:

Numerator Statement: Number of patients enrolled as Prime to the TRICARE Network with Type 1 or Type 2 diabetes, age 18-75, who had their most recent A1c performed sometime during the past year.

Denominator Statement: Number of patients who were continuously enrolled during the past 12 months with Type 1 or Type 2 diabetes, age 18-75.

Two types of data are used to identify members with diabetes (pharmacy data & claims/encounter data). *Note: Lab values are not used to identify diabetics, because of the high false positive rate associated with this method.*

Criteria to identify patients with diabetes via encounter data:
- Two or more outpatient visits with different dates of service
- Two or more non-acute inpatient visits
- One outpatient visit and one non-acute inpatient visit

- One acute inpatient visit
- One ED visit

Risk Adjustment: No

Measure Analysis Suggestions:

- Review chronic disease burden data to project provision of health care services and exams.

Data Sources:

- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)
- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- CHCS Laboratory
- Pharmacy Transaction Transcription Service (PDTS) (M2)

Reporting Frequency: Data are reported at the beginning and end of each option period.

Performance Metric: **Diabetes Care – LDL Test**

Description: Percent of patients enrolled as Prime to the TRICARE Network with Type 1 or Type 2 diabetes, age 18-75, who had their most recent LDL-C lab performed sometime during the past year.

Rationale: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 17 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20% of all tests and persons over 25. Many complications, such as imputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages. (HEDIS)

Type of Measure: Process

Improvement Noted As: An increase in the rate

Calculation:

Numerator Statement: Number of patients enrolled as Prime to the TRICARE Network with Type 1 or Type 2 diabetes, age 18-75, with at least one LDL-C test recorded during the past year.

Denominator Statement: Number of patients who were continuously enrolled during the past 12 months with Type 1 or Type 2 diabetes, age 18-75.

Two types of data are used to identify members with diabetes (pharmacy data & claims/encounter data). *Note: Lab values are not used to identify diabetics, because of the high false positive rate associated with this method.*

Criteria to identify patients with diabetes via encounter data:
• Two or more outpatient visits with different dates of service
• Two or more non-acute inpatient visits
• One outpatient visit and one non-acute inpatient visit
• One acute inpatient visit
• One ED visit

Risk Adjustment: No

Measure Analysis Suggestions:
- Review chronic disease burden data to project provision of health care services and exams.

Data Sources:
- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)
- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- CHCS Laboratory
- Pharmacy Data Transcription Service (PDTS) (M2)

Reporting Frequency: Data are reported at the beginning and end of each option period.

Performance Metric: **Diabetes Care – Retinal Eye Exams**

Description: Percent of patients enrolled as Prime to the TRICARE Network with Type 1 or Type 2, age 18-75, with retinal eye exams during the past 12 months or between 12 to 24 months if disease status criteria are met.

Rationale: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 17 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20% of all tests and persons over 25. Many complications, such as imputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages. (HEDIS)

Type of Measure: Process

Improvement Noted As: Increase in rate

Calculation:

Numerator Statement: Number of patients enrolled as Prime to the TRICARE Network with Type 1 or Type 2 diabetes, age 18-75 with a
- Retinal or dilated eye exam in the past 12 months
- Retinal or dilated eye exam between 12 to 24 months ago IF
  - The most recent A1c results is below 8.0% in the past 12 months

- o No insulin was prescribed or dispensed in the past 12 months
- o No diagnosis of diabetic retinopathy in the previous 12 to 24 months

<u>**Denominator Statement:**</u> Number of patients who were continuously enrolled during the past 12 months with Type 1 or Type 2 diabetes, age 18-75.

Two types of data are used to identify members with diabetes (pharmacy data & claims/encounter data). *Note: Lab values are not used to identify diabetics, because of the high false positive rate associated with this method.*

Criteria to identify patients with diabetes via encounter data:
- Two or more outpatient visits with different dates of service
- Two or more non-acute inpatient visits
- One outpatient visit and one non-acute inpatient visit
- One acute inpatient visit
- One ED visit

Risk Adjustment: No

Measure Analysis Suggestions:
- Review chronic disease burden data to project provision of health care services and exams.

Data Sources:
- Defense Eligibility Enrollment Registration System (DEERS)
- Standard Ambulatory Data Record (SADR) (M2)
- Standard Inpatient Data Record (SIDR) (M2):
- Purchased Care Claims Data (NETWORK) (M2)
- Composite Health System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- CHCS Laboratory
- Pharmacy Data Transcription Service (PDTS) (M2)

Reporting Frequency: Data are reported at the beginning and end of each option period.

Hypothetical Example of the External Trend Incentive Calculation
(Reference Section H, H.2)

Assume for this example that the incentive result is being calculated for Option Period 3 (OP3). Values below are rounded for simplicity in this example. See Table 1 below for a high-level summary of this example.

Step 1. Divide OP2 and OP3 underwritten contractor network and MTF workload for Contractor Network Prime enrollees into four categories: inpatient ADFM, inpatient NADFM, outpatient ADFM, and outpatient NADFM. The contractor network inpatient workload will reflect admissions tabulated from TRICARE Encounter Data (TED) records. The MTF inpatient workload will reflect dispositions tabulated from MTF Standard Inpatient Data Records (SIDRs). The contractor network outpatient workload will reflect outpatient visits tabulated from TED records. The MTF outpatient workload will reflect outpatient encounters tabulated from MTF Standard Ambulatory Data Records (SADRs), excluding telephone consults.

Step 2. For each of the four categories from Step 1, for both OP2 and OP3, calculate the contractor network workload per Contractor Network Prime enrollee and the MTF workload per Contractor Network Prime enrollee. The Contractor Network Prime enrollee counts for the denominators in this step will be the average of 12 monthly "snapshot" counts tabulated from monthly DEERS data files (the DEERS Point In Time Extract, or PITE, files). Then, for each of the four categories, for both OP2 and OP3, calculate the percentage share for contractor network workload per Network enrollee relative to contractor network plus MTF workload per Network enrollee.

Step 3. For each of the four categories, using the contractor network shares calculated in Step 2, calculate the trend in contractor network share from OP2 to OP3. For example, for inpatient ADFMs, if the contractor network share per Contractor Network Prime enrollee was 88% in OP2 and 90% in OP3, then the OP3 trend in contractor network share for this category would be 1.023 (90/88). This would be interpreted as an increase of 2.3 percent in the contractor network underwritten cost trend per Contractor Network Prime enrollee for inpatient care for ADFMs due to the increase in the contractor network share in this category.

Step 4. For each of the four categories from Step 1, for OP2 and OP3, tabulate the contractor network underwritten cost per Contractor Network Prime enrollee. The numerator would be tabulated from the Government costs on TED records for underwritten care for Contractor Network Prime enrollees and the denominator would be the same average enrollment counts from Step 2. Assume, for example, that for inpatient care for ADFMs, that the OP2 underwritten cost is $500 and the OP3 underwritten cost is $550. Then calculate the trend in underwritten cost per enrollee. In this example, this OP3 trend, for inpatient care for ADFMs, would be 1.10 (550/500).

Step 5. For each of the four categories, divide the cost trend per enrollee from Step 4 by the trend in contractor network share per enrollee from Step 3. In this example, the 1.10 trend from Step 4 would be divided by the 1.023 trend from Step 3, yielding a trend, normalized for contractor network share changes, of 1.075 for inpatient care for ADFMs.

Step 6. For each of the four categories, multiply the contractor network share-normalized trend factors from Step 5 by the prior year underwritten cost for Contractor Network Prime enrollees to calculate the MTF-normalized cost for the year being measured. For example, assume the OP2 (prior year) underwritten cost for ADFM inpatient care for Contractor Network Prime enrollees was $300 million. Multiplying $300 million by the 1.075 trend factor from Step 5 yields a contractor network share-normalized cost for OP3 of $322.5 million. By applying the cost trend per enrollee to the prior year's aggregate costs for this category of care, this step also normalizes the contractor network underwritten cost trend for any changes in the number of ADFM or NADFM Contractor Network Prime enrollees. Sum the MTF-normalized costs for all four categories of underwritten care. For example, assume this sum amounts to $1.50 billion for OP3.

Step 7. Subtract the net increase in OP3 underwritten health care costs (if any), relative to OP2, associated with contract change orders that have been negotiated by the Government and the contractor (e.g., benefit changes that affect underwritten costs for Contractor Network Prime enrollees). For example, assume change orders increased the OP3 underwritten costs for network enrollees by an estimated $10 million, relative to the OP2 level of costs. In this example, the OP3 cost, after normalizing for change orders, would be $1.490 billion (the $1.50 billion from Step 6 minus $10 million).

Step 8. Calculate the overall trend from the OP2 underwritten cost for Contractor Network Prime enrollees (tabulated in Step 4) to the normalized OP3 cost from Step 8. Assume the actual OP2 underwritten cost for Contractor Network Prime enrollees was $1.37 billion. In this example, then, the normalized OP3 trend would be 1.0876 (1.490/1.37).

Step 9. Compare the overall normalized cost trend from Step 8 to the CMS NHE trend standard (i.e., the portion of the CMS National Health Expenditures per capita trend described in Section H.2.5.1). Assume for this example that the relevant NHE trend is 6.0%, or a trend factor of 1.060. Then the contractor's normalized cost trend for Contractor Network Prime enrollees of 1.0876 is 2.76 percentage points higher than the CMS NHE trend standard (1.0876 - 1.060).

Step 10. Calculate the contractor's incentive result in percentage terms. The contractor's incentive result would be 30% of the trend differential from Step 9, or -0.828% (0.0276 x 30%). The incentive result is negative because the contractor's normalized cost trend was higher than the external standard; if the contractor's normalized trend had been lower than the external standard, a positive incentive would have resulted.

Step 11. The percentage incentive result from Step 10 would be multiplied by the normalized cost for OP 3 from Step 7 to calculate the dollar value of the incentive result. In this example, with the OP3 normalized cost of $1.49 billion and an incentive result of negative 0.828%, the dollar value of the incentive result would be a negative incentive payment of $12.3 million ($1.49 billion multiplied by -0.828%).

Table 1. High-Level Example of the External Trend Incentive

Actual underwritten cost trend per Contractor Network Prime enrollee, before normalizing (overall trend shown here for simplicity, actual calculation starts with separate trends for each of the 4 categories)	1.112
Actual underwritten cost trend per Contractor Network Prime enrollee, after normalizing for MTF-contractor network share, ADD/NADD network enrollment levels, and change orders (would be re-aggregated from the four categories)	1.0876
External trend standard (from CMS National Health Expenditures data)	1.0600
Trend Standard minus normalized underwritten trend	-0.0276
Contractor's incentive share	30%
Incentive result, to be applied to the normalized underwritten cost for Contractor Network Prime enrollees	-0.828%
Normalized underwritten cost for Contractor Network Prime enrollees	$1.49 billion
Incentive result, in dollars	-$12.3 million

EXHIBIT A

UnitedHealth MILITARY & VETERANS SERVICES

Service Assist Teams
Time & Material Rates

(b) (4)

[redacted]

CONTRACT # HT9402-12-C-0001

Annual Plans

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P020 Enrollment Plan		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM, Chapter 6, Section 1	TMA/TRO Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		N/A	See Block 16

16. REMARKS

Block 12: 90 days prior to start of health care delivery.
Block 13: 90 days prior to the start of each health care delivery period.

The plan shall address conditions and resources available to each MTF Commander; it shall be designed to inform beneficiaries of the availability of TRICARE Prime, and to facilitate enrollment of all beneficiaries, including active duty personnel. The plan shall establish enrollment goals and describe the methods to be used to accomplish the goals and purposes of the enrollment plan.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
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15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed In Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P030 Utilization Management Plan (UMP)		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 7 Sect 1, para 1.2	TMA/TRO-CLIN OPS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		N/A	See Block 16

16. REMARKS

Block 12 - No later than 90 calendar days prior to the start of health care delivery.
Block: 13 - At least 90 calendar days prior to the beginning of each option period for the duration of the contract.

The contractor shall fully describe in a written UM Plan all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting UM activities including utilization reviews, discharge planning, disease management programs, demand management programs or other techniques employed by the contractor to exercise clinical oversight. The contractor's plan shall delineate the organizational structure, responsibilities and authorities of personnel involved in the performance of UM activities, and specifically describe how the UM requirements of the contract will be accomplished. The contractor shall establish and document in the UM Program Plan specific, measurable goals for the evaluation of the overall effectiveness of the UM Program. Additionally, the contractor shall establish goals and thresholds for the internal monitoring and improvement of the UM Program as well as program components for measuring the improvements.

14. DISTRIBUTION

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Submit through the TMA E-commerce Extranet			
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Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P040 Clinical Quality Management Plan (CQMP)		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 7 Sect 4 para 1.0	TMA-OCMO/TRO-CLIN OPS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 60 calendar days following the award of the contract.
Block 13 - Annually, no later than 45 calendar days after the end of the fiscal year.

The contractor shall fully describe in a written CQMP the structural and functional components of the program to include:

Table of Contents
Executive Summary
Organizational Structure (describe the relationship of the CQMP to the organization)
Description of committee(s) structure, membership, functional responsibilities, and interface with other committees and meeting frequency)
Detail proposals for interacting with the TQMC and TRICARE Regional Directors
Description of clinical quality management program resources
Staff Qualifications and Responsibilities:
- Describe the minimum staffing qualification by position.
- Describe by position the responsibilities and authorities of personnel involved in the performance of quality management activities.

Quality Review Process
- Identification, review, evaluation, intervention, and reporting of Quality Issues (QIs) and Grievances related to the quality of patient care
- Criteria for selection of quality improvement projects and/or studies, or other improvement initiative
- Description of patient safety initiatives and quality program activities intended to reduce medical errors, increase patient safety, promote health and prevent disease or injury, and promote provider and beneficiary educational activities.
- National guidelines/benchmarking used for quality reviews
- Reporting processes and requirements

Measurable goals and thresholds for internal monitoring and improvement of the clinical quality plan and program
Description of policies and procedures to be used to identify and report patient safety/quality issues
Plans for review of medical records

The contractor shall address the prior TQMC Annual Report recommendations in their current year Annual Plan.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning,""Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P050 Education Plan		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 11 Sect 1 para 1.0	TMA-C&CS/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		N/A	See Block 16

16. REMARKS

Block 12 - No later than 180 calendar days prior to the start of health care delivery
Block 13 - No later than 90 calendar days prior to the start of each option period thereafter

The plan shall address how the MCSC plans to inform and educate TRICARE beneficiaries, TRICARE and MHS staff, and providers on all aspects of TRICARE programs.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: P060 External Resource Sharing Plan
3. SUBTITLE:
17. PRICE GROUP: NSP
18. ESTIMATED TOTAL PRICE: 0.00

4. AUTHORITY *(Data Acquisition Document No.)*: N/A
5. CONTRACT REFERENCE: TOM Chap 15 Sect 2 para 3.0
6. REQUIRING OFFICE: TMA/TRO-Prog Ops

7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: ANNLY
11. AS OF DATE: N/A
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES: Draft	Final: Reg	Final: Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 60 calendar days prior to the start of health care delivery
Block 13 - No later than 60 days prior to the start of each option period thereafter

The contractor shall submit an External Resource Sharing Plan. The plan shall discuss the contractor's general approach and methods for facilitating the identification of resource sharing opportunities throughout the region, an evaluation of the overall costs and savings potential agreements should generate for the Military Health System (MHS) and the contractor, and the contractor's approach to the development of agreements which adhere to the resource sharing guidelines at TOM Chapter 15, Section 2, paragraph 4. The plan shall include a description of the contractor's proposed methodology for developing a detailed cost analysis for each resource sharing proposal. The cost analysis shall include the MTF's actual cost of providing the services, the monetary benefits received by the contractor, projected workload, administrative costs, and the contractor's actual cost of providing services in support of external resource sharing providers.

G. PREPARED BY: Carol L. McCourt
H. DATE:
I. APPROVED BY: Laura L. Sells
J. DATE:

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P070 Alaska Clinical Quality Management Plan (CQMP) (West Region ONLY)		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 21 Sect 1 para 10.2	TMA-OCMO/TRO-W CLIN OPS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 5 - TOM, Chapter 7, Section 4, paragraph 1.0
Block 12 - No later than 60 calendar days following the award of the contract.
Block 13 - No later than 60 calendar days prior to the beginning of each option year for the duration of the contract

The contractor shall fully describe in a written CQMP the structural and functional components of the program to include:

Table of Contents
Executive Summary
Organizational Structure (describe the relationship of the CQMP to the organization)
Description of committee(s) structure, membership, functional responsibilities, and interface with other committees and meeting frequency)
Staff Qualifications and Responsibilities:
- Describe the minimum staffing qualification by position.
- Describe by position the responsibilities and authorities of personnel involved in the performance of quality management activities.

Quality Review Process
- Identification, review, evaluation, intervention, and reporting of Quality Issues (QIs) and Grievances related to the quality of patient care
- Criteria for selection of quality improvement projects and/or studies, or other improvement initiative
- Description of patient safety initiatives and quality program activities intended to reduce medical errors, increase patient safety, promote health and prevent disease or injury, and promote provider and beneficiary educational activities.
- National guidelines/benchmarking used for quality reviews
- Reporting processes and requirements

Measurable goals and thresholds for internal monitoring and improvement of the clinical quality plan and program
Interface with the National Quality Monitoring Contractor (NQMC)
Relationship to the Regional Director (RD)

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning,""Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.:

B. EXHIBIT:

C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:

E. CONTRACT/PR NO.: HT9402-12-C-0001

F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: P080 Alaska UM Plan (West Region ONLY)
3. SUBTITLE:
4. AUTHORITY (Data Acquisition Document No.): N/A
5. CONTRACT REFERENCE: TOM Chap 21 Sect 2, Chap 7 Sect 1
6. REQUIRING OFFICE: TMA/TRO-W-Prog Ops
7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: ANNLY
11. AS OF DATE: N/A
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than 90 calendar days prior to the start of health care delivery.
Block: 13 - At least 90 calendar days prior to the beginning of each option period for the duration of the contract.

The contractor shall establish a separate utilization management plan for care received in the state of Alaska. The plan shall describe all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting UM activities including utilization reviews, discharge planning, disease management programs, demand management programs or other techniques employed by the contractor to exercise clinical oversight. The contractor's plan shall delineate the organizational structure, responsibilities and authorities of personnel involved in the performance of UM activities, and specifically describe how the UM requirements of the contract will be accomplished. The contractor shall establish and document in the UM Program Plan specific, measurable goals for the evaluation of the overall effectiveness of the UM Program. Additionally, the contractor shall establish goals and thresholds for the internal monitoring and improvement of the UM Program as well as program components for measuring the improvements.

The plan shall recognize that the MTF PCM is responsible for services rendered to TRICARE Prime enrollees. As such, the MTF is responsible for issuing all authorizations for Prime enrollees. The contractor is responsible for ensuring that MTF issued authorizations are entered into all applicable contractor systems to ensure accurate, timely customer service and claims adjudication. The utilization management plan shall also recognize that network providers are the responsibility of the Government and shall ensure that any adverse finding is forwarded within 5 calendar days of identification to the TRO.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P090 Contingency Program Plan - Initial and Annual Updates		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.MGT.6, MGT.7., MGT.7.1	TMA/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		N/A	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - The draft Contingency Program Plan shall be submitted to the Regional Director 120 days prior to start of health care delivery for approval.

Plan should address following scenarios for each MTF: (1) backfill of MTF provider staff; (2) accommodating the MTF transfer of enrollees to network providers; and (3) MCSC actions to ensure continuous health care delivery to all beneficiaries (i.e., beneficiaries in the affected area of a disaster and evacuees who may be dislocated from the affected area).

Block 13 - Updated Plans required 60 days prior to start of each option year.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ______ TM ______ OTHER ______
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR
1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM P100 Disease Management Program Plan	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE RFP C.6.MM.4.	6. REQUIRING OFFICE TMA-OCMO/TRO-Prog Ops

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ: NO	9. DIST STATEMENT REQUIRED: B	10. FREQUENCY: ANNLY	12. DATE OF FIRST SUBMISSION: See Block 16	14. DISTRIBUTION
8. APP CODE: N/A		11. AS OF DATE: N/A	13. DATE OF SUBSEQUENT SUBMISSION: See Block 16	

16. REMARKS

Block 12 - No later than the start of health care delivery
Block 13 - No later than the start of each option period

The contractor shall submit a DM Program Plan. The contractor shall include a plan for accounting and reporting on the cost and performance of all DM programs, plus provide the specific guidelines and protocols to be utilized.

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST *(1 Data Item)*	*Form Approved* *OMB No. 0704-0188*

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	P110 Internal Quality Management/Quality Improvement Program Plan		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.MGT.2., F.5.	TMA/TRO/Contracting Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block: 12: Initial Submission within 30 calendar days following award.
Block: 13: Within 30 days following the start of each option period

Provide an Internal Quality Management/Quality Improvement Program Plan detailing all aspects of the contractor's quality program including the major components of the program, quality control activities, quality assurance functions, organizational responsibilities for quality management, and how identified quality problems will be monitored and resolved.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Annual Reports

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	A010 Clinical Quality Management Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 7 Section 4	TMA-OCMO/TRO-CLIN OPS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - Within 45 days of the end of the fiscal year.
Block 13 - Annually within 45 days of the fiscal year.

Annually, the contractor shall provide the CQMP Annual Report (AR). The report shall link to the Annual Plan and reflect the status of active Quality Improvement Initiatives, Quality Initiative Programs and studies. The AR shall reflect how well the goals and objectives of the CQMP Annual Plan were met. At a minimum the format and content of the AR shall address.

A. Clinical Quality Management Program Resources
1. Table of Organization for the CQMP Department and Relationship to Senior Management/Board
2. Certifying organization and criteria for certification of positions
3. Description of the organizational structure (description of the relationship of the CQMP to the organization)
4. Description of committees
   a. Structure
   b. Name of each committee
   c. Description of responsibilities
   d. Frequency of meetings
   e. Members
   f. Additional technical expertise available on ad hoc basis
   g. Staffing and reporting relationships
5. Staff qualifications and responsibilities
   a. Minimum staffing qualifications by position
   b. Description by position of the responsibilities and authorities of personnel involved in the performance of quality management activities

B. Outcomes of Quality Improvement Initiatives (QIIs), Quality Studies (QS),
1. QII and QS Consideration and Selection Process
2. Methodology used for identifying high priority topics
3. Rationale for selection of QIIs and QS
4. Report of findings to include a definition of the study, description of data collection, statement of hypothesis, analytic methods and population employed, data interpretation, and peer review process employed
5. Effect on quality of care

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

16. REMARKS *(Continued)*

6. Plan for follow on of the QIIs and QS

C. Outcome of Patient Safety/Quality Program Findings
1. Effect on reduction of medical errors
2. Effect on increasing patient safety
3. Effect on health promotion and disease and/or injury prevention
4. Provider and beneficiary educational activities initiated as a result of findings

D. Identification of Medical Records Reviewed and Purpose
1. Categories/reasons for medical records review
2. Potential quality issues (PQI)s per category
3. How managing/observing/monitoring category resulted in improvement in the care provided to beneficiaries

E. Report and analysis of all potential quality issues and confirmed quality issues
1. Stratify by event/indicator
2. Stratify by severity levels
3. Stratify by sentinel events
4. Actions taken as a result of identifying PQIs/QIs

F. Report of the AHRQ Patient Safety Indicator screening, interventions, and outcomes

G. Report of mortality in low risk DRGs, interventions, and outcomes

H. Assessment of the measurable goals and thresholds for the Internal Monitoring and Improvement of the Clinical Quality Management Plan and Program

I. Report of the measurable goals and recommendations for revisions to the Clinical Quality Management Plan based on year end outcomes

J. Report on the identification, review, evaluation, intervention, corrective actions, and reporting associated with grievances (beneficiary, clinician, facility initiated)

The CQMP AR will employ the use of national guidelines, benchmarks, common definitions and terminology, measures of performance, and reporting formats identified in the TOM to ensure comparability among MCSCs/DPS, direct care, and the rest of the nation.

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning," "Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	A020 Third Party Recoveries for Fiscal Year Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 10 Section 5	TMA-A-OGC	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - October 15 of the year following the year in which the contract began.
Block 13 - October 15 of each subsequent year.

The report shall include the following elements:
- Reporting Period (covering the 12 months of the previous fiscal year)
- The Contractor's Name and Region Name (if applicable)
- The Uniformed Service that the report figures are associated with (i.e., Army, Air Force, Navy & Marine Corps, Coast Guard, United States Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA)).

The contractor shall create a breakdown for each of the six Uniformed Services listed above which includes the following categories:
- Number of cases investigated for potential TPL.
- Total dollar amount actually paid on all claims investigated.
- Number of cases referred to the Uniformed Services for further investigation and collection:
- Actual dollar amount paid on all claims referred to the Uniformed Services for further investigation and collection.

For potential Third Party Liability (TPL) claims that were investigated and/or referred, the contractor shall list the Uniformed Services Claim Office (USCO) where the potential TPL case was referred. The contractor shall then report the appropriate figures for the categories listed immediately above, by the appropriate state(s) and/or countries.

See the attached Example for format.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit throgh the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Third Party Recoveries For Fiscal Year

(CONTRACTOR NAME) THIRD PARTY RECOVERIES FOR (REGION NAME) FISCAL YEAR (YEAR)				
ARMY				
USCO Claims Office Name	Number of cases involving TRICARE payments investigated for potential third party liability	Dollar amount of cases involving TRICARE payments investigated for potential third party liability	Number of cases involving TRICARE payments referred to Uniformed Services	Dollar amount of cases involving TRICARE payments referred to Uniformed Services
Ft. Rucker, AL	0	0	0	0
Red Stone Arsenal, AL	10	$27,500.25	2	$14,250.00
Fr. Wainwright, AK	20	$31,827.50	5	$5,367.20
TOTAL	30	$59,327.75	7	$19,617.20

- END -

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	A030 Fraud Prevention Savings Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 13 Sect 5 para 4.0	TMA-PI	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

16. REMARKS

Block 12 - No later than 45 calendar days after the end of the calendar year
Block 13 - No later than 45 calendar days after the end of the calendar year

The contractor shall report to the TMA PI the potential dollar amounts saved as a result of the activities/intervention of the anti-fraud/investigative units (e.g., disallowed services that otherwise would have been paid if the provider or pharmacy suspected of billing the program inappropriately had not been placed on prepayment review). This report shall include other relevant savings such as prepayment review savings, Other Health Insurance (OHI) savings, commercial software edits, recoupment savings, etc. or as requested by TMA PI.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM A040 Alaska Clinical Quality Management Report (West Region ONLY)	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE TOM Chap 7Sec 4, Chap 21 Sec 1	6. REQUIRING OFFICE TMA-OCMO/TRO-W

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ: NO	9. DIST STATEMENT REQUIRED: B	10. FREQUENCY: ANNLY	12. DATE OF FIRST SUBMISSION: Block 16	14. DISTRIBUTION
8. APP CODE: N/A		11. AS OF DATE: O	13. DATE OF SUBSEQUENT SUBMISSION: Block 16	

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - Within 60 calendar days following the end of the first option year

Block 13 - Within 60 calendar days of the end of each subsequent option year, and a final report 60 days following the end of the last option year of the contract.

Annually, within 60 calendar days of the end of the option year, the contractor shall provide a separate CQMP Annual Report for Alaska. The report shall link to the annual plan and reflect the status of quality improvement initiatives and studies underway.

At a minimum, the report format and content shall address:

Table of Contents
Executive Summary
Quality Improvement report
- Quality Improvement Initiatives outcomes
- Outcomes of Clinical Quality Studies and/or Quality Improvement Project (QIP)
  - Study and/or QIP in National Committee for Quality Assurance (NCQA) QIP/study format will be submitted as an attachment
- Outcomes of Patient Safety/Quality Program
- Annual analysis report of all Potential Quality Issues (PQIs) and all confirmed QIs stratified by event/indicator and severity levels/sentinel events
- Annual analysis report of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator screening, interventions and outcomes
- Annual Analysis report of mortality in low-risk Diagnostic Related Groups (DRGs), interventions and outcomes
- Assessment of the measurable goals and thresholds for the Internal Monitoring and Improvement of the CQMP and Program

Summary of the NQMC Interface
- Number and percent of agreements/disagreement to the NQMC findings
- Any initiatives undertaken as a result of the NQMC findings

Measurable Goals and Recommendations for Revisions to the CQMP based on the year end outcomes

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning," "Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

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Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM A050 Mental Health Rates Report	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY (Data Acquisition Document No.) N/A	5. CONTRACT REFERENCE TRM Chap 3 Sect 2, Para 3.0	6. REQUIRING OFFICE TMA-MB&RS	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY ANNLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE N/A	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - November 1 of each year.
Block 13 - November 1 of each year.

The contractor shall submit inpatient mental health, partial hospitalization (Half Day three to five hours and Full Day six or more hours) and RTC rates by facility. This data shall be reported in ASCII Format. The information shall include the Name of the Facility, Provider Number and the Location of the Facility. For inpatient mental health facilities indicate whether the facility is high volume or low volume and if high volume, the date when the facility became high volume. In addition, if a high volume inpatient mental health facility or RTC has been limited to a cap amount, so indicate (see 32 CFR 199.14 and TRM Chapter 7, Section 1 and 4). For those psychiatric hospitals affected by the deflator computation, the contractor shall submit the high volume rate no later than 30 days from the date the deflator factor is received. The data shall be submitted using the attached format.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Format for Submission of Mental Health Rates

	A	B	C
1	FIELD NAME	PICTURE	COMMENTS
2	Provider/Facility Number	X(9)	Employer Identification Number (EIN)
3	Fiscal Year	9(2)	Current Fiscal Year plus the two previous Fiscal Year Iterations
4	Facility Type	9(1)	1=Inpatient 2=Half Day Partial 3=Full Day Partial 4=RTC
5	Facility Name	X(40)	Name of the Facility Providing the Treatment
6	Facility Street Address	X(30)	Street Address of the Facility
7	Facility City	X(18)	City Where the Facility is Located
8	Facility State or Country Code	X(2)	State or Country Where Facility is Located (Alpha Code) (TRICARE Systems Manual (TSM), Chapter 2)
9	Facility Zip Code	X(9)	Zip Code Where Facility is Located
10	Per Diem Rate (Separate Record for each Per Diem Rate)	9(7)v99	1=Inpatient High Volume Per Diem Rate 2=Inpatient Low Volume Per Diem Rate - Adjusted by Wage Index and IDME Factors 3=Half Day Partial Hospitalization Per Diem Rate 4=Full Day Partial Hospitalization Per Diem Rate 5=RTC Per Diem Rate
11	High Volume Indicator	X(1)	Indicates if Facility is High Volume (1=True, 0=False)
12	High Volume Date	9(8)	If High Volume Indicator is True - Date Facility Became High Volume YYYYMMDD
13	High Volume Per Diem or RTC at Cap Amount	9(7)v99	If Per Diem has been Limited by Cap Amount, Provide Capped Amount

CONTRACT DATA REQUIREMENTS LIST *(1 Data Item)*	*Form Approved* *OMB No. 0704-0188*

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	A060 IDME Ratios for Children's Hospitals Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TRM Chap 6 Sect 8, Para 3.2.7.5.2.	TMA-MB&RS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		N/A	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - April 1 of each year.
Block 13 - April 1 of each year.

The contractors shall submit updated ratios for children's hospitals.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	
B. EXHIBIT	
C. CATEGORY: TDP ____ TM ____ OTHER ____	
D. SYSTEM/ITEM	
E. CONTRACT/PR NO.	HT9402-12-C-0001
F. CONTRACTOR	
1. DATA ITEM NO.	N/A
2. TITLE OF DATA ITEM	A070 Listing of High Volume Providers Report
3. SUBTITLE	
17. PRICE GROUP	NSP
4. AUTHORITY (Data Acquisition Document No.)	N/A
5. CONTRACT REFERENCE	TRM Chap 7 Sect 1, Para 3.6.1.2.1.
6. REQUIRING OFFICE	TMA-MB&RS
18. ESTIMATED TOTAL PRICE	0.00
7. DD 250 REQ	NO
8. APP CODE	N/A
9. DIST STATEMENT REQUIRED	B
10. FREQUENCY	ANNLY
11. AS OF DATE	0
12. DATE OF FIRST SUBMISSION	SEE BLOCK 16
13. DATE OF SUBSEQUENT SUBMISSION	SEE BLOCK 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - November 1 of the 1st option year or as otherwise directed.
Block 13 - November 1 of each year or as otherwise directed.

The contractor shall submit within 30 days of the request a listing of high volume providers that qualified as high volume during the most recent government fiscal year. Periodically, additional information may be requested by TMA concerning high volume providers. This requested information will be used in the calculation of the Deflator Factor (DF).

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR
1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM A080 List of PSA Zip Codes Report	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE RFP C.6.N.2.	6. REQUIRING OFFICE TMA/TRO

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY ANNLY	12. DATE OF FIRST SUBMISSION Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION Block 16

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - 60 calendar days after contract award
Block 13 - Within 60 calendar days of the start of each option year

The contractor shall provide a complete listing of all zip codes in the Region which constitute a Prime Service Area, by Prime Service Area.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning," "Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	C020 Statement on Auditing Standards (SAS) No. 70		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP Section G	TMA-CRM	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ANNLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - Send copy of the report within one month of completion.
Block 13 - Annually, send copy within one month of completion.

This report, required by the Sarbanes-Oxley Act of 2002, is normally done after the end of the contractor's fiscal year.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

As Required

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	R010 Start-up Plan (Phase-In)		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1 Sect 7 para 1.1	TMA-CO/TRO-Prog Ops	0.00

7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: ONE/R
11. AS OF DATE: N/A
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12: No later than 10 calendar days following contract award.
Block 13: Within 15 calendar days following the interface meetings.

This comprehensive plan shall be submitted in Microsoft® Project files. The plan shall address all events and milestones that need to occur for each functional area described in this contract to enable the start of health care delivery under this contract. The incoming contractor shall submit a revised start-up plan which incorporates the results of the Transition Specifications and Interface meetings. The final start-up plan will be incorporated into the contract at no cost to the Government.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM R011 Network Implementation Plan	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE TOM Chapter 5 Section 1	6. REQUIRING OFFICE TMA/TRO-Prog Ops

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY ONE/R	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE N/A	13. DATE OF SUBSEQUENT SUBMISSION N/A

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - 180 days prior to start of health care delivery

The contractor shall submit a plan detailing all phases of network implementation. The plan shall address all components of network development, implementation and operation in all TRICARE Prime Service Areas (PSAs) specified in the contract.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	R020 Serious Reportable Events (SREs)		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 7 Sect 4 para 2.0	TMA/TRO-Clinical Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	ASREQ	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		N/A	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Blocks 12 & 13 - Within two working days of when the contractor becomes aware of the event

The contractor shall report potential Serious Reportable Events (SREs) to the TRICARE Regional Office (TRO) within two working days from when the contractor becomes aware of the event including the beneficiary's name, beneficiary date of birth, enrollment status, brief summary of the event, location of event, and any contractor actions taken to date. The contractor shall report closure of the reported SRE to include closure date and summary of actions taken.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM R040 Accreditation Reports and Documentation	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY (Data Acquisition Document No.) N/A	5. CONTRACT REFERENCE RFP C.6.N.3.	6. REQUIRING OFFICE TMA-OCMO	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY ASREQ	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE ASREQ	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

16. REMARKS

BLK 12: Within 30 calendar days of the contractor's receipt from the accreditation organization.
BLK 13: Within 30 calendar days of the contractor's receipt from the accreditation organization.

The contractor's network, utilization management, and case management programs shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by this contract.

Contractor shall submit all documentation requesting accreditation, the initial and subsequent accreditation surveys reports along with the letters of accreditation and reaccreditation to the government.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY Carol L. McCourt	H. DATE	I. APPROVED BY Laura L. Sells	J. DATE

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ______ TM ______ OTHER ______

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.	N/A
2. TITLE OF DATA ITEM	R050 Service Assist Team After Action Report
3. SUBTITLE	
4. AUTHORITY (Data Acquisition Document No.)	N/A
5. CONTRACT REFERENCE	RFP C.6.CS.3.1.
6. REQUIRING OFFICE	TMA/TRO-Prog Ops
7. DD 250 REQ	NO
8. APP CODE	N/A
9. DIST STATEMENT REQUIRED	B
10. FREQUENCY	ASREQ
11. AS OF DATE	ASGEN
12. DATE OF FIRST SUBMISSION	See Block 16
13. DATE OF SUBSEQUENT SUBMISSION	See Block 16
17. PRICE GROUP	NSP
18. ESTIMATED TOTAL PRICE	0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than 2 weeks after the SAT is mobilized.
Block 13 - No less than monthly thereafter so long as the SAT is deployed.

Service Assist Team (SAT) After Action Report
After a SAT is deployed in accordance with Section C of the contract, the contractor shall provide the RD an after action report. The report shall continue on a monthly basis throughout the duration of the SAT period of deployment. At a minimum, the report sball include the number of briefings held, the audience, beneficiary workload (by type), other substantive outreach, and lessons learned.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Daily Reports

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	D010 Non-Financially Underwritten Contractor Payment/Check Issue Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP Section G	TMA-CRM	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	DAILY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the B2B Gateway			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - Report will be required upon the start of claims processing
Block 13 - Required with each cycle.

The contractor shall provide a Contractor Payment/Check Issue Report indicating payments issued for each cycle or approved release. The occurrence of this report is cycle dependent, but could occur as often as daily. Voided/Staledated payments must also be reported as negative amounts in this same format.

This shall be submitted electronically thru the B2B Gateway. Format is attached.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

PAYMENT/CHECK ISSUE REPORT REQUIREMENTS

Submitted through the B2B Gateway.

HEADER

Column Nbr	Field	Data size	TEDS ELN#	
1	Record type indicator (H = Header)	1	H	
2	Batch/Voucher ASAP Account Number	8	0-025	Non-Financially Underwritten - ASAP ID number assigned to contractor by TMA, CRM. Financially Underwritten - Use an abbreviated Contractor Name/Number (assigned by TMA, CRM)
3	TMA Authorization Number	8		e.g. 20050601 for first cycle in June
4	Record Count	6		Number of Records on this submission
5	Total Amount of Check Run	11		

DETAIL RECORDS
CHECKS/EFT

Column Nbr	Field	Data size	TEDS ELN# Institutional/ Non-Institutional	
1	Record type Indicator	1	D	
2	Batch/Voucher ASAP Account Number	8	0-025	Same as Header
3	Bank Account Number	10		Actual Contractor Bank Account
4	Check Number/EFT Trace Number	11		leave blank for any extra spaces
5	Check Payment Date	8		YYYYMMDD
6	Payee	50		leave blank for any extra spaces
7	Payee Tax ID/Provider Number	18	1-200/2-240	leave blank for any extra spaces
8	Interest Paid	11	1-145/2-112	Optional
9	Government Paid Amount	11	1-140/2-205	If Interest Is not listed separately, should include in the Government Paid Amount Field

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR
1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM D020 Financially Underwritten Contractor Payment/Check Issue Report	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE RFP Section G	6. REQUIRING OFFICE TMA-CRM

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	DAILY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the B2B Gateway			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - Report will be required upon the start of claims processing
Block 13 - Required with each cycle.

The contractor shall provide a Contractor Payment/Check Issue Report indicating payments issued for each cycle or approved release. The occurrence of this report is cycle dependent, but could occur as often as daily. Voided/Staledated payments must also be reported as negative amounts in this same format.

This shall be submitted electronically thru the B2B Gateway. Format is attached.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

PAYMENT/CHECK ISSUE REPORT REQUIREMENTS

Submitted through the B2B Gateway.

HEADER

Column Nbr	Field	Data size	TEDS ELN#	
1	Record type Indicator (H = Header)	1	H	
2	Batch/Voucher ASAP Account Number	8	0-025	Non-Financially Underwritten - ASAP ID number assigned to contractor by TMA, CRM. Financially Underwritten - Use an abbreviated Contractor Name/Number (assigned by TMA, CRM)
3	TMA Authorization Number	8		e.g. 20050601 for first cycle in June
4	Record Count	6		Number of Records on this submission
5	Total Amount of Check Run	11		

DETAIL RECORDS

CHECKS/EFT

Column Nbr	Field	Data size	TEDS ELN# Institutional/ Non-Institutional	
1	Record type indicator	1	D	
2	Batch/Voucher ASAP Account Number	8	0-025	Same as Header
3	Bank Account Number	10		Actual Contractor Bank Account
4	Check Number/EFT Trace Number	11		leave blank for any extra spaces
5	Check Payment Date	8		YYYYMMDD
6	Payee	50		leave blank for any extra spaces
7	Payee Tax ID/Provider Number	18	1-200/2-240	leave blank for any extra spaces
8	Interest Paid	11	1-145/2-112	Optional
9	Government Paid Amount	11	1-140/2-205	If Interest is not listed separately, should include in the Government Paid Amount Field

Monthly Reports

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M010 Toll Free Telephone Report Summary	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE TOM Chapter 1 Section 3	6. REQUIRING OFFICE TMA/TRO/Prog Ops	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY MTHLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

16. REMARKS

Block 12 - 20th of 2nd month after start of health care delivery
Block 13 - 20th of month covering previous entire month

Data shall be submitted using the following template.

Toll Free Telephone Summary:

Required Standards	Monthly Data: Month/Year
1. Total calls attempting to reach the contractor	XXX,XXX
2. Total calls received	XXX,XXX
3. All lines busy (ALB) in percentage (blockage rate)	XX.XX%
4. Percent of calls answered within two rings by the ARU	XX.XX%
5. Percent of calls handled by the ARU that were acknowledged within 20 seconds	XX.XX%
6. Number of calls answered by an individual within 30 seconds	XX.XX
7. Percent of calls answered by an individual within 30 seconds	XX.XX%
8a. Number of calls exceeding 30 seconds hold time during the entire telephone call	XXX,XXX
8b. Percentage of Total Calls with hold time within 30 seconds	XX.XX%
8c. Percentage of Total Calls with hold time more than 30 seconds	XXX,XXX%
9. Percentage of calls completely answered first contact (applies to calls transferred to an individual)	XX.XX%
10. Percentage of Inquires Not Closed on 1st contact and Subsequently Answered Within 10 business days	XXX.XX%
11. Availability of Toll Free Telephone Service (Monthly Operational Telephone Hours/Monthly Hours)	XXX.XX%

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY Carol L. McCourt	H. DATE	I. APPROVED BY Laura L. Sells	J. DATE

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M020 Enrollment Plan Implementation Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 1 Section 7	TMA/TRO Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	See Block 16	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		0	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 10: Monthly for the first 7 months after start of health care delivery.
Block 12: 30th calendar day after start of health care delivery.
Block 13: 10th of month covering previous month.

The report shall identify those areas in the contractor's approved start-up plan to be serviced by TRICARE Prime in which enrollment significantly exceeds or falls short of the targets established by the contractor in the approved enrollment plan, and outline corrective action plans for any deficiencies in the contractor's enrollment process which are significant deviations from the approved enrollment plan.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Sample Enrollment Plan Implementation Report

ENROLLMENT PLAN PROGRESS REPORT/ENROLLMENT PLAN IMPLEMENTATION REPORT					
FOR REPORTING PERIOD ENDING ____________					
PSA	NAME	ENROLLMENT DATA AT START - USED FOR PROJECTIONS	PROJECTION FOR END OF OPTION YEAR 1	CURRENT ENROLLMENT	PERCENTAGE ACHIEVED DURING MONTH

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M030 TQMC Findings Response Report	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY (Data Acquisition Document No.) N/A	5. CONTRACT REFERENCE TOM Chapter 7, Section 3.	6. REQUIRING OFFICE TMA-OCMO/CO/TRO-Clin Ops	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY MTHLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

16. REMARKS

Block 12 - 45th calendar day of the month following the start of health care delivery.
Block 13 - 15th day calendar day of the second month following the month reported.

The contractor shall provide written responses to all TQMC findings within 45 calendar days of receipt of the TQMC Monthly Validation Report. The contractor's responses shall state agreement, partial agreement, or nonconcurrence with each discrepancy found by the TQMC, and include supporting rationale, and proposed follow-up actions to address the issues.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

G. PREPARED BY Carol L. McCourt	H. DATE	I. APPROVED BY Laura L. Sells	J. DATE

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M040 CQM Monthly Quality Issues Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM, Chapter 7, Section 4	TMA-OCMO/TRO-CLIN OPS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12: No later than 10 calendar days after the end of the month.
Block: 13: No later than 10 calendar days after the end of the month.

The report will include the following data fields and in the below format:

1. Case Number
2. PQI/Grievance
3. Source
4. Prime Service Area
5. Indicator (s)
6. Severity Level
7. Corrective Action Activity
8. Case Status/Follow up action
9. Reported to CQM Committee (Y/N)

Severity Levels/Sentinel Events will be assigned as defined in the TOM, Chapter 7, Section 4.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

DD FORM 1423-1, FEB 2001 PREVIOUS EDITION MAY BE USED.

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M050 Right of First Refusal (ROFR) Referrals Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 8 Sect 5 para 6.2.2	TMA/TRO/Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - No later than the 10th calendar day following the end of the first month of health care delivery.
Block 13 - No later than the 10th calendar day following the end of the reported month.

The report shall include, by specialty, the number accepted by the MTF, the number individually rejected by the MTF, and the number rejected by the MTF as a result of the automatic rejection after one business day. A regional summary report, also by specialty, shall be provided.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
Each MTF Commander as specified in the TOM, Chapter 14, Section 3.			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ______ TM ______ OTHER ______

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M060 Customer Satisfaction Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 11 Section 2	TMA/TRO/Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

16. REMARKS

Block 12 - 20th of 2nd month after start of health care delivery
Block 13 - 20th of month covering previous entire month

The contractor shall submit a report indicating the state of customer satisfaction during the previous reporting period. The report shall include the contractor's measurement of satisfaction, by category, to include active duty personnel, dependents of active duty, retirees and other eligible beneficiaries under age 65, as well as Network providers, Non-network providers, MTF providers; and MTF Commanders.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M070 Education Presentation Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 11 Section 2	TMA-C&CS/TRO/Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - 10th of 2nd month after start of health care delivery
Block 13 - 10th of month covering previous entire month

The contractor shall submit the Education Presentation Report by market area with a copy provided to each appropriate MTF Commander. The report shall capture the following information:

Calendar of briefings held during the prior month
Number of attendees at each briefing
Type of attendees by beneficiary category
Location of briefing
Duration of briefing
Volume and type of materials distributed at each briefing
Summarize major issues/questions brought out at the briefing
Suggested follow-up actions to briefings
Major facility issues/concerns
Projected briefing schedule for the following month
Participating briefers (name and organization)
Contractor suggested changes (i.e., content of briefings, materials, etc.)

Data shall be submitted using the format attached.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
MTF Commanders			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Education Presentation Reporting
Prior Month Briefings Held Summary

Reporting Period ____________________

Briefing Date	Briefing Location	Presenter Name	Briefing Title

Education Presentation Reporting
Prior Month Briefings Held Detail
Reporting Period ____________

Briefing Date:

Briefing Title:

Briefing Location:

Responsibility:

Presenter Name:

Number Of Attendees:

Audience Type:

Duration Hours:

Volume & Type of Materials Distributed:	
Summary of Major Issues:	
Suggested Follow Up Actions:	
Major Facility Issues/Concerns:	
Suggestions For Improvements:	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M080 Debt Collection Assistance Officer Program Collection Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 11 Section 10	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - 45th calendar day following the start of the contract.
Block 13 - 15th calendar day of each month following the month reported.

The contractor shall furnish reports of all completed collection cases in an Excel spreadsheet format. Reports shall include:

Name of sponsor
Service of sponsor
Status of sponsor
Name of patient
Relationship to sponsor
Health care option involved in collection (Prime, Extra, or Standard)
Date(s) of service at issue
Date of claim(s) submission
Provider participation status on claim
Claim development history
-Was claim developed, and when
-Reason for development
-Was requested information received, and when
Claim adjudication and payment history
-Amount billed
-Amount allowed
-Reason(s) for difference
-Cost-share amount(s)
-Amount applied to deductible
-Amount paid
--To provider
--To beneficiary
--Payment date
--Payee
-Remaining beneficiary liability and reason
Any other information pertinent to understanding the resolution of the case (e.g., letter to provider, provider assent to contact MCSC prior to any future collection actions, etc.).

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: M090 Clinical Support Agreement Report
3. SUBTITLE:

17. PRICE GROUP: NSP

4. AUTHORITY (Data Acquisition Document No.): N/A
5. CONTRACT REFERENCE: TOM Chapter 15 Section 3
6. REQUIRING OFFICE: TMA/TRO/Prog Ops

18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: MTHLY
11. AS OF DATE: O
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
Performance			
Assessment Tool			
(PAT)			
MTF Commanders			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than the last working day of the second month following the start of health care delivery.
Block 13 - No later than the last working day of the month following the month being reported.

The contractor shall submit a monthly report detailing all CSA activities which occurred during the previous month. A copy shall also be provided to the appropriate MTF Commander. The contractor shall provide a separate report for each MTF and a summary.
This report shall be multi-part and shall include the following divisions:

CSA Requirements received during the previous month and the status of each;

CSA executed contract actions received from the PCO during the previous month and the status of each;
A status for each CSA Requirement received during a prior reporting period until one month following the receipt of a CSA executed contract action; and
A status for each CSA executed contract action received during a prior reporting period.

For all active CSA executed contract actions issued by the PCO, the contractor shall also provide the following:

The number of CSA personnel by executed contract action and by specialty or personnel type working in each MTF;
The number of hours worked by CSA personnel, by executed contract action, and by specialty or personnel type for each MTF;
The types and numbers of services provided for each executed contract action, i.e., the number of visits, treatments, procedures, tests;
The total salaries, compensation, and expenses paid by the contractor in support of the services provided for each executed contract action.
Total reimbursement expected from the government for services rendered through each executed contract action during the reporting period.

G. PREPARED BY: Carol L. McCourt
H. DATE:
I. APPROVED BY: Laura L. Sells
J. DATE:

CONTRACT DATA REQUIREMENTS LIST *(1 Data Item)*	*Form Approved* *OMB No. 0704-0188*

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M100 HIPAA Privacy Disclosure Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM, Chapter 19 Section 3	TMA Privacy Office	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - 10th day of the second month following the start of services (i.e., the contract phase-in period). Covers the entire period from the dates services began.
Block 13 - 10th of each subsequent month, covering complaints received in the previous month

For each complaint received, provide:
--Beneficiary's name;
--Nature of the complaint;
--Steps taken by the contractor to resolve the complaint;
--Date of the initial complaint;
--Date of expected resolution;
--Date complaint resolved.

Format shall be tabular; a sample is attached.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

HIPAA Privacy Disclosure Report (Sample)

CONTRACTOR MONTHLY COMPLAINT REPORT TO THE REGIONAL DIRECTOR					
BENEFICIARY'S NAME	NATURE OF COMPLAINT	CONTRACTOR'S STEPS TO RESOLVE COMPLAINT	DATE OF INITIAL COMPLAINT	DATE OF EXPECTED RESOLUTION	DATE COMPLAINT RESOLVED

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M110 TRICARE Reserve Select Premium Activity Report	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY (Data Acquisition Document No.) N/A	5. CONTRACT REFERENCE TOM Chapter 22 Sect 1 para 9.2	6. REQUIRING OFFICE TMA-CO/TRO	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY MTHLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - 45th calendar day following the start of the contract.
Block 13 - 15th calendar day of each month following the month reported.

The contractor shall submit a TRS Premium Activity Report. This report shall support the wire transfer of dollars in accordance with TOM Chapter 22 and the finance provisions of the contract.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M170 Beneficiary Services Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.CS.1, F.5.	TMA/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - 15th of 2nd month after start of health care delivery
Block 13 - 15th of month covering previous entire month

The report shall consist of the following:

Enrollment Applications Received;
Enrollment Applications Completed Processing (by beneficiary category);
Enrollment Applications Pending (not completed processing by Military Treatment Facility (MTF));
Enrollment Applications Aging.

The enrollment applications are to be reported separately based on the enrollment standards and the portability enrollment standards (new, transfer/portability, Primary Care Manager (PCM) batch, PCM individual, disenrollment, correct enrollment discrepancy);

Number of beneficiaries enrolled to network within MTF enrollment ZIP codes;
Number of walk-in inquiries at each TRICARE Service Center (TSC) (listed separately by TSC and a summary of all);
Average time to acknowledge and assist a visitor at each TSC (listed separately by TSC and a summary of all);
TSC Operating Hours - The contractor shall report any situation, by TSC, where the TSC had a delayed opening or closed, with an explanation as to the circumstances of why the TSC was not open during the required hours Monday through Friday (Federal holidays excepted);
Number of users at kiosks (by kiosk if kiosks were proposed in the contract) and the top 5 reasons or source of information the kiosk users were seeking; and
Complaint or inquiry issues
- Report the top 10 reasons for written inquiries;
- Report the top 10 reason for telephone inquiries.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

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A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR
1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M180 Case Management/Disease Management Report	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE RFP C.6.MM.4.1.	6. REQUIRING OFFICE TMA-OCMO/TRO-ClinOps

17. PRICE GROUP	NSP
18. ESTIMATED TOTAL PRICE	0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY MTHLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12: 20th of 2nd month following start of health care delivery.

Block 16: 20th of month covering previous entire month

REPORT INCLUSIONS:.

1. Summary Report of CM/DM Activity provided per Branch of Service, DMIS, and Region Report will:
   a. Identify total number of cases identified and/or referred, total number of cases opened, total number of cases closed, total number of cases MCSC coordinated for care and transfer of patients who required transfer from one location to another, as received or changed within reporting month.
   b. These numbers will have Active Duty and Non-Active duty subtotals and a grand total per Service, DMIS, and Region
   c. All Active Duty reports will have annotations and totals for all Wounded Warrior reporting requirements as well as source of CM identification.

2. Detailed Reports - By Branch of Service and DMIS
   a. Identify by Name, EDIPN, beneficiary category, CPT, Diagnostic Code(s) for each individual with a case open (active and inactive), pending, or screened during the reporting month. Include all case notes, source of identification, and reason for not accepting CM/DM. This report will include all cases closed during that reporting month.
   b. Identify by Name, EDIPN, bene cat, CPT, Diagnostic Code(s) a historical record of all cases previously closed. Include all case notes.
   c. All Active Duty records will have annotations and totals for all Wounded Warrior reporting requirements as well as source of CM identification.
   d. As a part of the detailed reports or as a separate report but with all required elements, list all CM activities resulting in cost savings or costs avoidance. This shall include specific CM activity conducted resulting in said savings.

3. List of all specific high cost conditions and specific disease conditions screened for referral to MCSC CM Programs and acceptance rates.

G. PREPARED BY Carol L. McCourt	H. DATE	I. APPROVED BY Laura L. Sells	J. DATE

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M190 Cycletime Aging Reports		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.CP.1. and MGT.14	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTLHY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submitted through TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - 45th calendar day following the start date of the contract
Block 13 - 15th calendar day of each month (or the first workday following the 15th calendar day if the 15th is not a business day) following the report period throughout the duration of the contract.

The contractor shall submit a TRICARE Contractor Monthly Cycletime Aging Reports by Status Location, TMA Form 743 (see attached for content and instructions), of combined network and non-network data for the contract. The report will cover the period beginning on the first day of the report month, and ending on the last day of the report month. (Separate data for each state within the contractor's jurisdiction is not required on a monthly basis, but must be available upon request from TMA.) Any adjustments to previously submitted data require an explanation of the differences, including the cause, either in the "Remarks" section or in a separate report. The Cycletime Aging report shall be submitted as one report containing data sheets to include but not limited to each of the required cycletime reports listed in the instructions. At the discretion of TMA, or as required by law, contractor performance statistics contained in this report may be released to the public.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

1.0. INSTRUCTIONS FOR TRICARE CONTRACTOR MONTHLY CYCLE TIME/ AGING REPORT - NETWORK/NON-NETWORK/MEDICARE BRAC, TMA FORM 743

1.1. Information Requirement

The contractor shall submit a TRICARE Contractor Monthly Cycle Time/Aging Report as one report containing separate data sheets for each of the following reports:

- Claims Cycle Time/Aging Report
- SHCP Cycle Time/Aging Report
- TPR Cycle Time/Aging Report
- TRPADFM Cycle Time/Aging Report

1.2. Instructions For Preparation

1.2.1. Section A: Claims And Adjustment Claims - Retained

Retained claims are those claims retained by the contractor for processing to completion or development. This includes claims that contain sufficient information to allow processing to completion and all claims for which missing information may be developed from in-house sources, including DEERS and contractor operated or maintained electronic, paper, or film files.

1.2.1.1. A.1.a. - Professional (All Outpatient Services)

Enter the number of professional and supplier retained TRICARE claims and adjustment claims which were processed to final disposition during the report period (include drug and outpatient Extended Care Health Option (ECHO) claims).

1.2.1.2. A.1.b. - Institutional (All Inpatient Services)

Enter the number of institutional retained TRICARE claims which were processed to final disposition during the report period (include inpatient ECHO claims).

1.2.1.3. A.1.c. - Total Processed

Enter the sum of A.1.a., plus A.1.b.

1.2.1.4. A.2. - Total Pending End Of Month

Enter the total number of retained claims and adjustment claims which are pending.

1.2.1.5. A.3. - Returned Claims

Enter the number of TRICARE claims returned to the sender.

1.2.2. Section B: Claims And Adjustment Claims - Excluded Claims

Claims that are excluded from the 30 and 60 day claims processing cycle time standards are to be reported in this section. This includes claims retained by the contractor while being developed for missing or discrepant information that cannot be obtained from in-house sources; third party liability claims requiring development, claims requiring Government intervention and claims requiring interface with other contractors.

1.2.2.1. B.1.a. - Total Processed

Enter the total number of processed claims and adjustment claims that are excluded from the 30 and 60 day claims processing cycle time standards. (Totals of Section B.1.a.(2)-(5).)

1.2.2.2. B.1.a.(1) - Government Direction

Enter the total number of claims processed that are excluded from the 120 calendar day claims processing cycle time standard (claims that were pended at Government direction over 60 calendar days).

1.2.2.3. B.1.a.(2) - Government Intervention

Enter the total number of pending claims requiring Government intervention and are pended up to 60 calendar days.

1.2.2.4. B.1.a.(3) - TPL Claims

Enter the total number of claims processed that required third-party liability development.

1.2.2.5. B.1.a.(4) - Other Contractor Interface

Enter the total number of claims processed that required other contractor interface. (Claims held as a result of actions required between a prime contractor and a subcontractor or between subcontractors of a prime contractor are not excluded from the 30 and 60 day claims processing cycle time standards and should be reported in Section A.1.c.)

1.2.2.6. B.1.a.(5) - Development Claims

Enter the total number of claims processed that were developed for missing or discrepant information that could not have been obtained from in-house sources.

1.2.2.7. B.2. - Total Pending End-Of-Month

Enter the total number of pending claims that are excluded from the 30 and 60 calendar day claims processing cycle time standards. (Totals of Sections B.2.a., b., c., and d.)

1.2.2.8. B.2.a. - Government Intervention

Enter the total number of pending claims requiring Government intervention (include those claims pended at Government direction).

1.2.2.9. B.2.b. - TPL

Enter the total number of pending claims for third-party liability development.

1.2.2.10. B.2.c. - Other Contractor Interface

Enter the total number of pending claims requiring other contractor interface. (Claims held as a result of actions required between a prime contractor and a subcontractor or between subcontractors of a prime contractor are not excluded from the 30 and 60 day claims processing cycle time standards and should be reported in Section A.1.2.)

1.2.2.11. B.2.d. - Development Claims

Enter the total number of pending claims that were developed for missing or discrepant information that could not have been obtained from in-house sources.

1.2.3. Section C: Correspondence

NOTE: This section pertains only to receipts of written inquires and requests and excludes receipts of incoming telephone inquiries.

1.2.3.1. C.1.a. - Routine Correspondence

Enter the number of pieces of routine correspondence processed to completion through the use of a written or documented telephonic reply. Several pieces of routine correspondence attached to a single inquiry shall be counted as one piece of correspondence.

1.2.3.2. C.1.b. - Priority Correspondence

Enter the number of pieces of priority correspondence processed to completion through the use of a written reply. Several pieces of priority correspondence attached to a single inquiry shall be counted as one piece of correspondence.

1.2.3.3. C.1.c. - Collection Action Cases

Enter the number of collection action cases (cases received directly from the contractor) processed to completion through the use of a written reply.

1.2.3.4. C.1.d. - Total Processed To Completion

Enter the sum of C.1.a., plus C.1.b., plus C.1.c.

1.2.3.5. C.2.a. - Routine Correspondence

Enter the number of pieces of routine correspondence received which have not been processed to completion. Several pieces of routine correspondence attached to a single inquiry shall be counted as one piece of correspondence.

1.2.3.6. C.2.b. - Priority Correspondence

Enter the number of pieces of priority correspondence which have not been processed to completion. The pieces of priority correspondence attached to a single inquiry shall be counted as one piece of correspondence.

1.2.3.7. C.2.c. - Total Pending

Enter the sum of C.2.a., plus C.2.b.

1.2.4. Section D: Expedited Preadmission/Preprocedure Reconsiderations (Expedited Appeals)

1.2.4.1. D.1. - Expedited Appeal Cases Completed

Enter the number of expedited appeal cases which were processed to completion.

1.2.4.2. D.2. - Expedited Appeal Cases Pending

Enter the number of expedited appeal cases which have not been processed to completion.

1.2.5. Section E: Nonexpedited Medical Necessity Reconsiderations (including Factual Determinations)

1.2.5.1. E.1. - Nonexpedited Medical Necessity Appeal Cases Completed

Enter the number of nonexpedited medical necessity appeal cases which were processed to completion.

1.2.5.2. E.2. - Nonexpedited Medical Necessity Appeal Cases Pending

Enter the number of nonexpedited medical necessity appeal cases which have not been processed to completion.

1.2.6. Section F: Nonexpedited Factual Determinations

1.2.6.1. F.1. - Nonexpedited Factual Determination Appeal Cases Completed

Enter the number of nonexpedited factual determination appeal cases which were processed to completion.

1.2.6.2. F.2. - Nonexpedited Factual Determination Appeal Cases Pending

Enter the number of nonexpedited factual determination appeal cases which have not been processed to completion.

1.2.7. Section G: Grievances

1.2.7.1. G.1. - Grievances Completed

Enter the number of grievance cases which were processed to completion.

1.2.7.2. G.2. - Grievances Pending

Enter the number of grievances which have not been processed to completion.

1.2.8. Section H: Remarks

2.0. Use to explain any unusual entries or variations in Sections B, C, D, E, F, or G, including the number of pending and completed appeal cases (identify expedited or non-expedited and the number of days category (e.g. 1-15, 16-30, etc.) the appeals are reported) that were rescheduled at the request of the appealing party.

TRICARE Contractor Monthly Cycle Time/Aging Report - Network/Non-Network/Medicare BRAC, TMA Form 743

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT
Network/Non-Network/Medicare BRAC

State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

SECTION A. CLAIMS AND ADJUSTMENT CLAIMS - RETAINED CLAIMS

Total Working Days During Month:	TOTAL	1-10 Days	11-21 Days	22-30 Days	31-60 Days	61-90 Days	91-120 Days	Over 120 Days
1. Processed to Completion								
a. Professional (All Outpatient Services, ECHO, Drugs)								
b. Institutional (All Inpatient Services, ECHO)								
c. Total Processed								
2. Total Pending End of Month								
3. Returned Claims								

SECTION B. CLAIMS AND ADJUSTMENT CLAIMS - EXCLUDED CLAIMS

	TOTAL	1-10 Days	11-21 Days	22-30 Days	31-60 Days	61-90 Days	91-120 Days	Over 120 Days
1. Processed to Completion								
a. Total Processed								
(1) Government Direction								
(2) Government Intervention								
(3) TPL								
(4) Other Contractor Interface								
(5) Development Claims								
2. Total Pending End-of-Month								
a. Government Intervention								
b. TPL								
c. Other Contractor Interface								
d. Development Claims								

TRICARE Contractor Monthly Cycle Time/Aging Report - Network/Non-Network/Medicare BRAC, TMA Form 743 (Continued)

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT
Network/Non-Network/Medicare BRAC

State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

SECTION C. CORRESPONDENCE

	TOTAL	1-10 Days	11-15 Days	16-30 Days	31-45 Days	Over 45 Days
1. PROCESSED TO COMPLETION						
a. Routine Correspondence						
b. Priority Correspondence						
c. Collection Action Correspondence						
d. Total Processed to Completion						
2. PENDING						
a. Routine Correspondence						
b. Priority Correspondence						
c. Collection Action Correspondence						
d. Total Processed to Completion						

SECTION D. EXPEDITED APPEALS

	TOTAL	1-3 Days	4-7 Days	8-15 Days	16-30 Days	Over 30 Days
1. EXPEDITED APPEALS COMPLETION						
2. EXPEDITED APPEALS PENDING						

SECTION E. NONEXPEDITED MEDICAL NECESSITY APPEALS

	TOTAL	1-15 Days	16-30 Days	31-60 Days	61-90 Days	Over 90 Days
1. NONEXPEDITED APPEALS COMPLETION						
2. NONEXPEDITED APPEALS PENDING						

TRICARE Contractor Monthly Cycle Time/Aging Report - Network/Non-Network/Medicare BRAC, TMA Form 743 (Continued)

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT
Network/Non-Network/Medicare BRAC

State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

SECTION F. NONEXPEDITED FACTUAL DETERMINATION APPEALS

	TOTAL	1-15 Days	16-30 Days	31-60 Days	61-90 Days	Over 90 Days
1. NONEXPEDITED APPEALS COMPLETION						
2. NONEXPEDITED APPEALS PENDING						

SECTION G. GRIEVANCES

	TOTAL	1-15 Days	16-30 Days	31-60 Days	Over 60 Days
1. GRIEVANCES COMPLETED					
2. GRIEVANCES PENDING					

Section F - Remarks

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M200 Workload Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.CP.2.	TMA-CO/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - 45th calendar day following the start date of the contract
Block 13 - 15th calendar day of each month (or the first workday following the 15th calendar day if the 15th is not a business day) following the report period

See the attached document for content and completion instructions.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

1.0. INSTRUCTIONS FOR TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT - NETWORK/NON-NETWORK/MEDICARE BRAC, TMA FORM 742

1.1. Information Requirement

The contractor shall electronically submit to the TMA, Claims Operations Office and Regional Director, a TRICARE Contractor Monthly Workload Report as one report containing separate data sheets for each of the following workload reports:

- Claims Workload Report
- SHCP Workload Report
- TPR Workload Report
- TPRADFM Workload Report

1.2. Instructions For Preparation

1.2.1. Section A: Claims

For purposes of this chapter, a claim is defined as any request for payment for services rendered related to care and treatment of a disease or injury which is received from a claimant by a TMA contractor on any TMA-approved claim form or approved electronic media. Reports of services rendered, which do not result in the submission of claims, as defined above, are not to be included in the reports required by this chapter.

1.2.1.1. A.1.a. - Pending End Of Prior Month

Enter the number reported in line A.4. on the preceding month's report.

1.2.1.2. A.1.a.(1) - Correction to Prior Month's Report

Enter the net number of claims which were actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section requires an explanation in Section C, "Remarks."

1.2.1.3. A.1.b. - Adjusted Opening Pending

Enter the result of A.1.a., plus or minus A.1.a.(1).

1.2.1.4. A.2. - Receipts

Enter the number of claims accepted in the custody of the contractor. Estimate the number of non-keyed network versus non-network receipts by applying the percentage of keyed claims received during the reporting period.

EXAMPLE:

Total monthly receipts	= 10,000	
Total Keyed Receipts	= 8,000	(5,000 network = 62.5%)
		(3,000 non-network = 37.5%)
Total Non-Keyed Receipts	= 2,000	(2,000 X 62.5% = 1,250 network)
		(2,000 X 37.5% = 750 non-network)

Add estimates for non-keyed receipts to keyed receipts:

Total Receipts Network	= 5,000	+ 1,250	= 6,250
Total Receipts Non-Network	= 3,000	+ 750	= 3,750

1.2.1.5. **A.2.a. - Network Claims Receipts**

Enter the number of network claims accepted in the custody of the contractor. Estimate the number of non-keyed network receipts by applying the percentage of keyed claims received during the reporting period.

1.2.1.5.1. **A.2.a.(1) - EMC Network Claims Receipts**

Enter the number of processed EMC network claims included in the receipts reported in A.2.a.

1.2.1.6. **A.2.b. - Non-Network Claims Receipts**

Enter the number of non-network claims accepted in the custody of the contractor. Estimate the number of non-keyed network receipts by applying the percentage of keyed claims received during the reporting period.

1.2.1.6.1. **A.2.b.(1) - EMC Non-Network Claims Receipts**

Enter the number of processed EMC non-network claims included in the receipts reported in A.2.b.

1.2.1.7. **A.2.c. - Transfers**

Claims received in A.2. above which are forwarded to another TRICARE contractor having jurisdiction of processing.

1.2.1.8. **A.2.d. - Returns**

Enter the number of claims returned to the claimant.

1.2.1.9. **A.2.e. - Net Receipts**

Enter the result of A.2., minus A.2.c. and A.2.d.

1.2.1.10. **A.3. - Processed to Completion**

Enter the total number of claims paid, applied toward the deductible, or denied.

1.2.1.11. **A.4. - Pending End of Month**

Enter the difference between A.1.b. plus A.2.c. minus A.3.

1.2.1.12. A.5. - Point of Service (POS) - Processed to Completion

Enter the total number of the claims paid under POS. The POS numbers shall be included in the total number of claims processed to completion in line A.3. (This is not applicable to the TRICARE Dual Eligible FI Contract.)

1.2.2. Section B: Adjustment Claims

An adjustment is a correction of the payment or the payment record information on a claim previously processed to completion. (Refer to Chapter 11, Section 1, paragraph 5.0.)

1.2.2.1. B.1.a. - Pending End of Prior Month

Enter the number reported in line B.4. of the preceding month's report.

1.2.2.2. B.1.a.(1) - Correction to Prior Month's Report

Enter the net number of adjustments to processed claims which were actually overstated or understated in the previous month's report will be entered using a plus (+) or minus (-). Any entry in this section requires a narrative explanation in Section C, "Remarks."

1.2.2.3. B.1.b. - Adjusted Opening Pending

Enter the results of B.1.a., plus or minus B.1.a.(1).

1.2.2.4. B.2. - Receipts

Enter the number of adjustment claims identified during the month. (Refer to Chapter 11, Section 1, paragraph 5.0.)

1.2.2.5. B.3. - Processed To Completion

Enter the number of adjustment claims which were processed to completion.

1.2.2.6. B.4. - Pending End Of Month

Enter the number of adjustment claims identified which have not been processed to completion. Line B.4. is the difference between B.1.b., plus B.2., minus B.3.

1.2.3. Section C: Remarks

1.2.4. Section D: Inquiries

1.2.4.1. D.1. - Telephone Inquiries Received

Enter the total number of incoming telephone inquiries received in all locations, including service center(s). This data must be substantiated by a log or other documentation. Do not include routine operating calls (calls received from individuals or organizational components within the contractor's operations involving the conduct of normal business) or personal calls.

1.2.4.2. D.2. - Walk-In's

Report total walk-ins in all locations, including the service center(s).

1.2.4.3. **D.3. - Routine Correspondence**

Report in this section the data related to all routine correspondence received into custody. Routine correspondence regarding a returned claim that requires a response shall be reported here. Grievances, collection action cases or requests for appeal should not be reported here. Letters from beneficiaries or providers resubmitting the claim or claim documentation shall not be reported. Questions concerning charges allowed should be included as "routine correspondence." Requests for "Reconsiderations" on issues considered not appealable and untimely requests for reconsiderations shall be counted as routine correspondence.

1.2.4.4. D.3.a.(1) - Pending End Of Prior Month

Enter the number reported in line D.3.d. of the prior month's reports.

1.2.4.5. D.3.a.(1)(a) - Correction To Prior Month's Report

Enter the net number of pieces of routine correspondence which were actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section requires a narrative explanation in Section E, "Remarks," below.

1.2.4.6. D.3.a.(2) - Adjusted Opening Pending

Enter the result of D.3.a.(1), plus or minus D.3.a.(1)(a).

1.2.4.7. D.3.b. - Receipts

Enter the number of pieces of routine correspondence accepted into custody.

1.2.4.8. D.3.c. - Processed To Completion

Enter the number of pieces of routine correspondence completed, regardless of the manner in which it was completed; i.e., written, telephone, or other.

1.2.4.9. D.3.d. - Pending End Of Month

Enter on line D.3.d. the difference between D.3.a.(2), plus D.3.b., minus D.3.c.

1.2.4.10. D.4. - Priority Correspondence

Enter appropriate data in this section regarding correspondence received from the Office of the Assistant Secretary of Defense (Health Affairs), TMA, members of Congress, and others designated as priority by the contractor.

1.2.4.11. D.4.a.(1) - Pending End Of Prior Month

Enter the number reported in line D.4.d. of the prior month's report.

1.2.4.12. D.4.a.(1)(a) - Correction To Prior Monthly Report

Enter the net number of pieces of priority correspondence which were actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section (plus or minus) requires a narrative explanation in Section E, "Remarks," below.

1.2.4.13. D.4.a.(2) - Adjusted Opening Pending

Enter the result of D.4.a.(1), plus or minus D.4.a.(1)(a).

1.2.4.14. D.4.b. - Receipts

Enter the number of pieces of priority correspondence accepted into custody.

1.2.4.15. D.4.c. - Processed To Completion

Enter the number of pieces of priority correspondence completed.

1.2.4.16. D.4.d. - Pending End Of Month

Enter on line D.4.d., the difference between D.4.a.(2), plus D.4.b., minus D.4.c.

1.2.4.17. D.5. - Collection Action Cases

Enter data in this section regarding collection action cases received directly by the contractor. (Cases referred by the DCAOs shall be reported as priority correspondence.)

1.2.4.18. D.5.a.(1) - Pending End Of Prior Month

Enter the number reported in line D.5.d. of the prior month's report.

1.2.4.19. D.5.a.(1)(a) - Correction To Prior Monthly Report

Enter the net number of collection action cases which were actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section (plus or minus) requires a narrative explanation in Section E, "Remarks," below.

1.2.4.20. D.5.a.(2) - Adjusted Opening Pending

Enter the result of D.5.a.(1), plus or minus D.5.a.(1)(a).

1.2.4.21. D.5.b. - Receipts

Enter the number of collection action cases accepted into custody.

1.2.4.22. D.5.c. - Processed To Completion

Enter the number of collection action cases completed.

1.2.4.23. D.5.d. - Pending End Of Month

Enter on line D.5.d., the difference between D.5.a.(2), plus D.5.b., minus D.5.c.

1.2.5. Section E: Remarks

1.2.6. Section F: Expedited Preadmission/Preprocedure Reconsiderations (Expedited Appeal Cases)

Report in this section the data related to all expedited appeal cases received into custody. The contractor shall count as a receipt any case received in which the appealing party is raising objection to the contractor's preadmission/preauthorization medical necessity determination. Correspondence concerning non-appealable issues is to be reported in Section D, "Inquiries." Correspondence qualifying as a grievance is to be reported in Section I, "Grievances."

1.2.6.1. F.1.a. - Pending End Of Prior Month

Enter in the "Total" column the number reported in line F.4. of the preceding month's report.

1.2.6.2. F.1.a.(1) - Correction To Prior Month's Report

Enter in the "Total" column the net number of expedited appeal cases actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section will require a narrative explanation in Section E, "Remarks," above.

1.2.6.3. F.1.b. - Adjusted Opening Pending

Enter in the "Total" column the result of F.1.a., plus or minus F.1.a.(1).

1.2.6.4. F.2. - Receipts

Enter in the "Total" column the number of expedited appeal cases accepted in the custody of the contractor.

1.2.6.5. F.3.a. - Initial Decision Upheld

Enter the number of expedited appeal cases receiving final replies when the contractor affirmed the initial decision as being correct in its entirety.

1.2.6.6. F.3.b. - Initial Decision Partially Upheld

Enter the number of expedited appeal cases receiving final replies when the contractor affirmed only a portion of the initial decision as being correct.

1.2.6.7. F.3.c. - Initial Decision Reversed

Enter the number of expedited appeal cases receiving final replies when the contractor reversed the initial decision in its entirety.

1.2.6.8. F.3.d. - Total Processed To Completion

Enter the sum of F.3.a., plus F.3.b., plus F.3.c.

1.2.6.9. F.4. - Pending End Of Month

Enter the sum of F.1.b., plus F.2., minus F.3.d.

1.2.7. Section G: Nonexpedited Medical Necessity Reconsiderations

Report in this section the data related to all nonexpedited medical necessity appeal cases received into custody. The contractor shall count as a receipt any case received in which the appealing party is raising objection to the contractor's determination of coverage. Correspondence concerning nonappealable issues is to be reported in Section D, "Inquiries." Correspondence qualifying as a grievance is to be reported in Section I, "Grievances."

1.2.7.1. G.1.a. - Pending End Of Prior Month

Enter in the "Total" column the number reported in line G.4. of the preceding month's report.

1.2.7.2. G.1.a.(1) - Correction To Prior Month's Report

Enter in the "Total" column the net number of nonexpedited medical necessity appeal cases actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section will require a narrative explanation in Section E, "Remarks," above.

1.2.7.3. G.1.b. - Adjusted Opening Pending

Enter in the "Total" column the result of G.1.a., plus or minus G.1.a.(1).

1.2.7.4. G.2. - Receipts

Enter in the "Total" column the number of nonexpedited medical necessity appeal cases accepted in the custody of the contractor.

1.2.7.5. G.3.a. - Initial Decision Upheld

Enter the number of nonexpedited medical necessity appeal cases receiving final replies when the contractor affirmed the initial decision as being correct in its entirety.

1.2.7.6. G.3.b. - Initial Decision Partially Upheld

Enter the number of nonexpedited medical necessity appeal cases receiving final replies when the contractor affirmed only a portion of the initial decision as being correct.

1.2.7.7. G.3.c. - Initial Decision Reversed

Enter the number of nonexpedited medical necessity appeal cases receiving final replies when the contractor reversed the initial decision in its entirety.

1.2.7.8. G.3.d. - Total Processed To Completion

Enter the sum of G.3.a., plus G.3.b., plus G.3.c.

1.2.7.9. G.4. - Pending End Of Month

Enter the sum of G.1.b., plus G.2., minus G.3.d.

1.2.8. Section H: Nonexpedited Factual Determinations

Report in this section the data related to all non-expedited factual determination appeal cases received into custody. The contractor shall count as a receipt any case received in which the appealing party is raising objection to the contractor's determination of coverage. Correspondence concerning nonappealable issues is to be reported in Section D, "Inquiries." Correspondence qualifying as a grievance is to be reported in Section I, "Grievances."

1.2.8.1. H.1.a. - Pending End Of Prior Month

Enter in the "Total" column the number reported in line G.4. of the preceding month's report.

1.2.8.2. H.1.a.(1) - Correction To Prior Month's Report

Enter in the "Total" column the net number of nonexpedited factual determination appeal cases actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section will require a narrative explanation in Section E, "Remarks" above.

1.2.8.3. H.1.b. - Adjustment Opening Pending

Enter in the "Total" column the result of H.1.a., plus or minus H.1.a.(1).

1.2.8.4. H.2. - Receipts

Enter in the "Total" column the number of nonexpedited factual determination appeal cases accepted in the custody of the contractor.

1.2.8.5. H.3.a. - Initial Decision Upheld

Enter the number of nonexpedited factual determination appeal cases receiving final replies when the contractor affirmed the initial decision as being correct in its entirety.

1.2.8.6. H.3.b. - Initial Decision Partially Upheld

Enter the number of nonexpedited factual determination appeal cases receiving final replies when the contractor affirmed only a portion of the initial decision as being correct.

1.2.8.7. **H.3.c. - Initial Decision Reversed**

Enter the number of nonexpedited factual determination appeal cases receiving final replies when the contractor reversed the initial decision in its entirety.

1.2.8.8. **H.3.d. - Total Processed To Completion**

Enter the sum of H.3.a., plus H.3.b., plus H.3.c.

1.2.8.9. **H.4. - Pending End of Month**

Enter the sum of H.1.b., plus G.2., minus G.3.d.

1.2.9. **Section I: Grievances**

In this section report the data related to all grievances received into custody.

1.2.9.1. **I.1.a. - Pending End Of Prior Month**

Enter in the "Total" column the number reported in I.4. of the preceding month's report.

1.2.9.2. **I.1.a.(1) - Correction To Prior Month's Report**

Enter in the "Total" column the net number of grievances actually overstated or understated in the previous month's report using a plus (+) or minus (-). Any entry in this section will require a narrative explanation in Section E, "Remarks," above.

1.2.9.3. **I.1.b. - Adjusted Opening Pending**

Enter in the "Total" column the result of I.1.a., plus or minus I.1.a.(1).

1.2.9.4. **I.2. - Receipts**

Enter in the "Total" column the number of grievances accepted in the custody of the contractor. The contractor should count as a receipt any case received which meets the definition of a grievance.

1.2.9.5. **I.3. - Total Processed To Completion**

Enter the number of grievances completed.

1.2.9.6. **I.4. - Pending End Of Month**

Enter the sum of I.1.b., plus I.2., minus I.3.

TRICARE Contractor Monthly Workload Report - Network/Non-Network/Medicare BRAC, TMA Form 742

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT
Network/Non-Network/Medicare BRAC

State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

Section A. CLAIMS	Total Working Days (during month):
1. OPENING PENDING	
a. Pending End of Prior Month	
(1) Corrections to Prior Month's Report (+ or -)	
b. Adjusted Opening Pending	
2. RECEIPTS	
a. Network Claims Receipts	
(1) EMC Network Claims Receipts	
b. Non-Network Claims Receipts	
(1) EMC Non-Netork Claims Receipts	
c. Transfers	
d. Returns	
e. Net Receipts	
3. PROCESSED TO COMPLETION	
4. PENDING END OF MONTH	
5. POINT OF SERVICE (POS) PROCESSED TO COMPLETION	

SECTION B. ADJUSTMENT CLAIMS	TOTAL
1. OPENING PENDING	
a. Pending End of Month	
(1) Correction to Prior Month's Report (+ or -)	
b. Adjusted Opening Pending	
2. RECEIPTS	
3. PROCESSED TO COMPLETION	
4. PENDING END OF MONTH	

SECTION C. Remarks:

Report Prepared By:	Telephone No.	Date Prepared:
Report Approved By (Authorized Officer's Signature)		Date Submitted to TMA:

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT Network/Non-Network/Medicare BRAC			
State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

Section D. INQUIRIES	TOTAL
1. Telephone Inquiries Received	
2. Walk-Ins	
3. Routine Correspondence	
a. Opening Pending	
(1) Pending End of Prior Month	
(a) Corrections to Prior Month's Report (+ or -)	
(2) Adjusted Opening Pending	
b. Receipts	
c. Processed to Completion	
d. Pending End of Month	
4. Priority Correspondence	
a. Opening Pending	
(1) Pending End of Prior Month	
(a) Corrections to Prior Month's Report (+ or -)	
(2) Adjusted Opening Pending	
b. Receipts	
c. Processed to Completion	
d. Pending End of Month	
5. Collection Action of Correspondence	
a. Opening Pending	
(1) Pending End of Prior Month	
(a) Corrections to Prior Month's Report (+ or -)	
(2) Adjusted Opening Pending	
b. Receipts	
c. Processed to Completion	
d. Pending End of Month	

SECTION E. Remarks:

TRICARE Contractor Monthly Workload Report - Network/Non-Network/Medicare BRAC, TMA Form 742 (Continued)

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT Network/Non-Network/Medicare BRAC			
State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

SECTION F. EXPEDITED APPEALS	TOTAL
1. Opening Pending	
a. Pending End of Prior Month	
(1) Corrections to Prior Month's Report (+ or -)	
b. Adjusted Opening Pending	
2. Receipts	
3. Processed to Completion	
a. Initial Decision Upheld	
b. Initial Decision Partially Upheld	
c. Initial Decision Reversed	
d. Total Processed to Completion	
4. Pending End of Month	
Section G. NON EXPEDITED MEDICAL NECESSITY APPEALS	**TOTAL**
1. Opening Pending	
a. Pending End of Prior Month	
(1) Corrections to Prior Month's Report (+ or -)	
b. Adjusted Opening Pending	
2. Receipts	
3. Processed to Completion	
a. Initial Decision Upheld	
b. Initial Decision Partially Upheld	
c. Initial Decision Reversed	
d. Total Processed to Completion	
4. Pending End of Month	
Section H. NON EXPEDITED FACTUAL DETERMINATION APPEALS	**TOTAL**
1. Opening Pending	
a. Pending End of Prior Month	
(1) Corrections to Prior Month's Report (+ or -)	
b. Adjusted Opening Pending	
2. Receipts	
3. Processed to Completion	
a. Initial Decision Upheld	
b. Initial Decision Partially Upheld	
c. Initial Decision Reversed	
d. Total Processed to Completion	
4. Pending End of Month	

TRICARE Contractor Monthly Workload Report - Network/Non-Network/Medicare BRAC, TMA Form 742 (Continued)

TRICARE CONTRACTOR MONTHLY WORKLOAD REPORT Network/Non-Network/Medicare BRAC			
State:	Contractor Name:	Contract No.:	Report Period (MM/YY)

Section I. GRIEVANCES	TOTAL
1. Opening Pending	
a. Pending End of Prior Month	
(1) Corrections to Prior Month's Report (+ or -)	
b. Adjusted Opening Pending	
2. Receipts	
3. Processed to Completion	
4. Pending End of Month	
Remarks	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M210 Medical Management Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.MM.4., F.5.1.3.	TMA-OCMO/TRO-Clin Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than the 15th of the second month following the start of health care delivery

Block 13 - No later than the 15th of each month

The report shall include:

Number of patients, by PSA, in the medical management program, by medical management program component (e.g., case management, disease management, high cost, etc., based on the contractor's proposal).

Effect of the MMP on MTF optimization to include care/treatment required; source of care; cost-control; timeliness; integration of MTF and purchased care services; access to clinical services; non-clinical services required and obtained, including funding source; and future requirements and treatment/funding sources.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:

B. EXHIBIT:

C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:

E. CONTRACT/PR NO.: HT9402-12-C-0001

F. CONTRACTOR:

1. DATA ITEM NO.: N/A

2. TITLE OF DATA ITEM: M220 Network Adequacy Report

3. SUBTITLE:

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

4. AUTHORITY (Data Acquisition Document No.): N/A

5. CONTRACT REFERENCE: RFP C.6.N.1., N.4., N.7.

6. REQUIRING OFFICE: TMA/TRO-Prog Ops

7. DD 250 REQ: NO

8. APP CODE: N/A

9. DIST STATEMENT REQUIRED: B

10. FREQUENCY: MTHLY

11. AS OF DATE: O

12. DATE OF FIRST SUBMISSION: See Block 16

13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 5 - TOM Chapter 1, Section 7, Paragraph 2.2.2
Block 12 - 10th of 2nd month after contract award
Block 13 - 10th of month covering previous entire month

A Network Adequacy Report, format as per attachment, shall be submitted monthly for performance assessment of sufficient number of providers in each specialty.

The contractor shall provide the following information by Prime service area:

- The number of network providers by specialty and the total number of providers in the PSA
- The number of additions and deletions by specialty;
- Areas lacking adequate providers to meet access standards, including numbers of providers and specialties that are lacking in each area, and the contractor's plan to meet access requirements;
- Activities undertaken to contract with additional providers in areas lacking networks to meet the prescribed network standards;
- A listing of PCMs (both civilian and military) and the number of enrollees assigned to each PCM by Prime service area;
- A brief description of activities planned during the next reporting period.

G. PREPARED BY: Carol L. McCourt

H. DATE:

I. APPROVED BY: Laura L. Sells

J. DATE:

Region Network Adequacy Report
By Prime Service Area

Report:

Market:
PSA:

Report Period:

Specialty Category	Providers Targeted	Current Providers Contracted	Prior Providers Contracted	Number Over/Under Target	Current/ Prior Change	Network Fit % Targeted Providers Contracted
PRIMARY CARE	381	1262	1255	881	7	100%
ALLERGY/IMMUNOLOGY	23	33	33	10	0	100%
ANESTHESIOLOGY	57	140	137	83	3	100%
CARDIOLOGY	19	223	224	204	1	100%
DERMATOLOGY	15	62	63	47	1	100%
ENT	23	78	76	55	2	100%
GASTROENTEROLOGY	12	116	116	104	0	100%
GENERAL SURGERY	57	120	122	63	2	100%
HEMATOLOGY/ONCOLOGY	6	117	116	111	1	100%
NEPHROLOGY	6	47	46	41	1	100%
NEUROLOGY	10	75	75	65	0	100%
OB/GYN	57	268	267	211	1	100%
OPHTHALMOLOGY	29	127	126	98	1	100%
ORTHOPEDIC SURGERY	23	86	84	63	2	100%
PATHOLOGY	29	33	33	4	0	100%
PHYSICAL MEDICINE	5	35	34	30	1	100%
PSYCHIATRY	12	84	85	72	1	100%
PULMONARY DISEASE	6	79	82	73	3	100%
RADIOLOGY	57	238	235	181	3	100%
UROLOGY	19	82	82	63	0	100%
OTHER MEDICAL SPECIALTY	18	185	184	167	1	100%
OTHER SURGICAL SPECIALTY	68	173	172	105	1	100%
BEHAVIORAL HEALTH	46	414	415	368	1	100%
Total	978	4077	4062	3099	15	100%
ALLIED HEALTH PROFESSIONALS	80	440	433	360	7	100%
HOSPITAL	20	39	39	19	0	100%
MENTAL HEALTH FACILITIES/UNITS	1	9	9	8	0	100%

Created:

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M230 Network Inadequacy Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 5, Sect 1, para 2.2	TMA/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - 30th of 2nd month after start of health care delivery
Block 13 - 30th of month covering previous entire month

The report shall include any instances of network inadequacy relative to the Prime and/or Extra service areas and shall include a corrective action plan with each notice of an instance of network inadequacy. Network inadequacy is defined as any occurrence of a Prime beneficiary being referred to a network provider outside of the time and/or distance standards (except when the beneficiary waives the access standards) or any beneficiary being referred to a non-network provider.

Report formats are attached.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol. L. McCourt		Laura L. Sells	

Network Inadequacy Report Sample Format

Monthly Referrals to Non-Network Providers Due to Network Inadequacy By Prime Service Area and Specialty							
Market:					Referral Period:		
Area:					PSA:		
Specialty/Provider Type	Provider Name/Provider Address	Approval Date	Auth ID/ Reason Code	Ordering Provider	Sponsor ID/Patient	CAP No./Open	CAP Status

REFERRALS TO NON-NETWORK PROVIDERS CORRECTIVE ACTION PLAN (CAP) HISTORY AS OF: ____________	
MARKET:	
AREA:	
PSA:	
CAP NUMBER:	OPENED ON:
COMMENT DATE:	
CAP STATUS:	
COMMENT:	
COMMENT DATE:	
CAP STATUS:	
COMMENT:	
COMMENT DATE:	
CAP STATUS:	
COMMENT:	
COMMENT DATE:	
CAP STATUS:	
COMMENT:	
COMMENT DATE:	
CAP STATUS:	
COMMENT:	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:

B. EXHIBIT:

C. CATEGORY: TDP ______ TM ______ OTHER ______

D. SYSTEM/ITEM:

E. CONTRACT/PR NO.: HT9402-12-C-0001

F. CONTRACTOR:

1. DATA ITEM NO.: N/A

2. TITLE OF DATA ITEM: M240 Non-Financially Underwritten Accounts Receivable Report including Supplemental Reports

3. SUBTITLE:

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

4. AUTHORITY *(Data Acquisition Document No.)*: N/A

5. CONTRACT REFERENCE: RFP Section G

6. REQUIRING OFFICE: TMA-CRM

7. DD 250 REQ: NO

8. APP CODE: N/A

9. DIST STATEMENT REQUIRED: B

10. FREQUENCY: MTHLY

11. AS OF DATE: See Block 16

12. DATE OF FIRST SUBMISSION: See Block 16

13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 11 - 25th of the month being reported

Block 12 - 3rd Federal work day of the month following the start of claims processing.

Block 13 - 3rd Federal work day of each subsequent month for the previous month.

Separate Reports are required for Public Receivables and Federal Government Receivables. One set of reports should be Public Receivables and a second set for Federal Government Receivables. Federal Government Receivables include the Department of Veteran's Affairs, Public and Indian Health Service Clinics, Coast Guard medical facilities or any other medical facilities directly controlled by the Federal Government

The contractor shall submit all of the following Accounts Receivable reports by the third Federal work day of the month following each month of claims processing. Attached are the format and instructions for each report:

Table 1: Accounts Receivable Summary Report

Table 2: Accounts Receivable - Amounts Written Off Detail Report

Table 3: Accounts Receivable - Debts Transferred to TMA Detail Report

Table 4: Accounts Receivable - Ending Outstanding Receivables Detail Report

Formats and instructions are attached.

G. PREPARED BY: Carol L. McCourt

H. DATE:

I. APPROVED BY: Laura L. Sells

J. DATE:

DD FORM 1423-1, FEB 2001 PREVIOUS EDITION MAY BE USED. Page ____ of ____ Pages

ACCOUNTS RECEIVABLE SUMMARY REPORT

Contractor Name | ASAP ID#
Sub-Contractor Name | Month of Report

A. SUMMARY OF ACCOUNTS RECEIVABLES

	NUMBER OF ACCOUNTS	AMOUNT
1. Beginning Receivables		$
2. New Receivables		$
3. Collections On Receivables		$
4. Adjusted Amounts		$
5. Amounts Written Off		$
6. Transferred To TMA		$
7. Ending Receivables (Lines A.1 + A.2 - A.3 +/- A.4 - A.5 - A.6)		$

B. OUTSTANDING RECEIVABLES

	NUMBER OF ACCOUNTS	AMOUNT
1. Principal Amount ≥ $600.00		
a. Not Delinquent		$
b. Delinquent		
1) 1-30 Days		$
2) 31-60 Days		$
3) 61-90 Days		$
4) 91-180 Days		$
5) 181-365 Days		$
6) > 1 Year to 2 Years		$
7) > 2 Years to 6 Years		$
8) > 6 Years to 10 Years		$
9) > 10 Years		$
10) Total Delinquent Receivables ≥ $600.00 (Total of Lines B.1.b.1 thru B.1.b.9)		$
c. Total Outstanding Receivables ≥ $600.00 (Total of Lines B.1.a + B.1.b.10)		$
2. Principal Amount ≤ $599.99		
a. Not Delinquent		$
b. Delinquent		
1) 1-30 Days		$
2) 31-60 Days		$
3) 61-90 Days		$
4) 91-180 Days		$
5) 181-365 Days		$
6) > 1 Year to 2 Years		$
7) > 2 Years to 6 Years		$
8) > 6 Years to 10 Years		$
9) > 10 Years		$
10) Total Delinquent Receivables ≤ $599.99 (Total of Lines B.2.b.1 thru B.2.b.9)		$
c. Total Outstanding Receivables ≤ $599.99 (Total of Lines B.2.a + B.2.b.10)		$
3. Total Receivables		
a. Not Delinquent (Lines B.1.a + B.2.a)		$
b. Delinquent		
1) 1-30 Days (Lines B.1.b.1 + B.2.b.1)		$
2) 31-60 Days (Lines B.1.b.2 + B.2.b.2)		$
3) 61-90 Days (Lines B.1.b.3 + B.2.b.3)		$
4) 91-181 Days (Lines B.1.b.4 + B.2.b.4)		$
5) 181-365 Days (Lines B.1.b.5 + B.2.b.5)		$
6) > 1 Year to 2 Years (Lines B.1.b.6 + B.2.b.6)		$
7) > 2 Years to 6 Years (Lines B.1.b.7 + B.2.b.7)		$
8) > 6 Years to 10 Years (Lines B.1.b.8 + B.2.b.8)		$
9) > 10 Years (Lines B.1.b.9 + B.2.b.9)		$
10) Total Delinquent Receivables (B.1.b.10 + B.2.b.10)		$
c. Total Outstanding Receivables (Line B.1.c + B.2.c)		$

Instructions For Accounts Receivable Summary Report

The heading of this report shall include the following:

ACTIVITY FOR THE MONTH OF: All transactions shall be as of the end of the month being reported.
CONTRACTOR NAME: Name of the Prime Contractor
SUBCONTRACTOR NAME: Name of the Subcontractor
ASAP ID NUMBER: The ASAP number used for payments/collections and other bank transactions.

A. SUMMARY ACCOUNTS RECEIVABLE

1. Beginning receivables - Carried forward from line A.7. of the prior month report.

2. New receivables - Enter the number and amount of new receivables generated during the reporting period.

3. Collections on receivables - Include in the Amount column, all installment payments and offset adjustments received. In the Number of Cases column, include only the final installment or offset.

4. Adjusted Amounts - Enter the number and amount of corrections made to previously reported receivables and refunds of amounts previously reported as corrections. The amount noted on this line must be footnoted.

5. Amounts written off - Cases 300 days delinquent with balances less than $600, the case shall be written-off and reported on line A.5. This case shall be dropped from the accounting records. However, the offset flag shall remain until the claims processing contract has elapsed or full payment is received. If full collection through offset is effected, then the write-off shall be reversed in the amount collected through offset (net of current write-offs) and the payment recorded (line A.3.).

6. Transferred to TMA - When a case with a balance of $600 or more is transferred in accordance with Chapter 11, the balance transferred shall be reported on line A.6. An adjustment claim shall be processed for the total amount collected to the point of transfer either in payment or offset. If a transferred receivable is collected inadvertently through offset, the claims processing unit shall telephonically inform TMA, Recoupment Branch (303) 676-3741 of the collection. The amount of the offset shall reduce current transfers and be included in line 3. If a receivable has reached the mandatory time limit for transfer, but a claim is pending for offset which will not be paid until the next month, this receivable may be retained, reported on a footnote, and transferred the following month. The footnote shall provide the debtor's name, sponsor's name and last 4 digits of SSN, amount of debt, amount of potential offset, and the expected date of transfer. A copy of each report containing such footnotes shall be sent to the Chief, Recoupment Branch, Office of General Counsel, TMA, 16401 East Centretech Parkway, Aurora, CO 80011-9066.

7. Ending receivables - Total ending receivable balance to be carried forward to A.1. for the next reporting period.

B. OUTSTANDING RECEIVABLES

Not delinquent is normally 30 days from the date of initial notification of the debt or from the date of the last installment payment. Installments will be aged based on the date of the last payment. If the installment payment is delinquent (over 30 days from the last payment) the remaining unpaid balance will be reported in the proper aged category depending on amount of debt either (lines B.1.b.1. through 4. or lines B.2.b.1. through 4.).

B.1.c. = B.1.a. + B.1.b.7.

B.1.b.7. = Sum of B.1.b.1 through 6.

B.2.c. = B.2.a. + B.2.b.7.

B.2.b.7. = Sum of B.2.b.1. through 6.

B.3.c. = B.3.a. + B.3.b.7.

B.3.b.7. = Sum of B.3.b.1. through 6.

C. Ending Outstanding Receivables

Installments in excess of 24 months or monthly payments of less than $50.00 are not normally allowed. Include all installment and non-installment receivables. The total of the amount on line C.3. must equal the amount on line A.7. and B.3.c. of the report.

Table 2: Accounts Receivable - Amounts Written Off Detail Report

CONTRACTOR NAME

SUBCONTRACTOR NAME

ASAP ID#

MONTH OF REPORT

			DAYS DELINQUENT											
NAME	SSN^a/TIN	NOT DELINQUENT	1-30	31-60	61-90	91-150	151-180	181-300	301-365	>1YR AND <2YRS	>2YRS AND <6YRS	>6YRS AND <10YRS	>10YRS	TOTALS
	TOTALS:													

Instructions:

This report shall list the cases that make up the total shown on line A.5. - Amounts Written Off - on the Accounts Receivable Summary Report.

Aging shall be based on date of delinquency.

Note that this report has an additional split for aging (181-300 and 301-365) compared to the other two Supplemental Reports.

a. For security reasons, report only the last 4 digits

Table 3: Accounts Receivable - Debts Transferred To TMA Detail Report

CONTRACTOR NAME

SUBCONTRACTOR NAME

ASAP ID#

MONTH OF REPORT

			DAYS DELINQUENT										
NAME	SSN[A]/TIN	NOT DELINQUENT	1-30	31-60	61-90	91-150	151-180	181-365	>1YR AND <2YRS	>2YRS AND <6YRS	>6YRS AND <10YRS	>10YRS	TOTALS
	TOTALS:												

Instructions:

This report shall list the cases that make up the total shown on line A.6. - Transferred to TMA - on the Accounts Receivable Summary Report.

Aging shall be based on date of delinquency.

a. For security reasons, report only the last 4 digits

Table 4: Accounts Receivable - Ending Outstanding Receivables Detail Report

CONTRACTOR NAME

ASAP ID#

SUBCONTRACTOR NAME

MONTH OF REPORT

			DAYS DELINQUENT										
NAME	SSN^A/TIN	NOT DELINQUENT	1-30	31-60	61-90	91-150	151-180	181-365	>1YR AND <2YRS	>2YRS AND <6YRS	>6YRS AND <10YRS	>10YRS	TOTALS
	TOTALS:												

Instructions:

This report shall list the cases that make up the total shown on line A.7. - Ending Receivable - on the Accounts Receivable Summary Report.

Aging shall be based on date of delinquency.

a. For security reasons, report only the last 4 digits

CONTRACT DATA REQUIREMENTS LIST

(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M250 Non-Financially Underwritten Bank Account Reconciliation Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP Section G	TMA-CRM	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 – Within 30 calendar days following the end of the month of the first month of claims processing.

Block 13 - Within 30 calendar days following the end of the month being reported

Each month, after reconciling the bank account, the contractor shall provide the TMA, CRM with a balanced Financially Underwritten Bank Account Reconciliation Report for each bank account, within 30 calendar days following the end of the month being reported. These reports shall contain all transactions affecting the financially underwritten bank accounts. Attached are the format and instructions for this report.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

NON-FINANCIALLY UNDERWRITTEN FUNDS BANK ACCOUNT RECONCILIATION

CONTRACTOR NAME
SUB-CONTRACTOR NAME

NON UNDERWRITTEN BANK ACCOUNT RECONCILIATION

FOR THE MONTH OF ________

BANK ACCOUNT NUMBER	FISCAL YEAR	ASAP ID NUMBER	PREVIOUS MONTH'S YEAR TO DATE TOTAL	THIS MONTHS TRANSACTIONS	REPORTING MONTH'S YEAR TO DATE TOTAL
I. TRANSACTIONS DONE THRU THE FEDERAL RESERVE - RICHMOND (Year to Date)					
Net Total of Drawdowns against Federal Reserve Bank:		TOTAL SECTION I			
II. TRANSACTIONS RELATED TO CASH IN BANK ACCOUNT					
A. Routine Bank Account Transactions:					
1. TEDS Vouchers (All TEDs submitted to TMA):					
2. Non-TEDS Routine Vouchers (as applicable):					
a Capital Equipment/Direct Medical Education (CAP/DME) Claims:					
b. Health Professional Shortage Areas (HPSA/PSA)					
c. Medicare Crossover Fees (TDEFIC only)					
d. Any additional programs established in the future					
3. Credits not submitted on TEDS:					
a. Receipts under $110 (must include list of each transaction): (Reference: TOM Chapter 11, Section 4, Paragraph 13.0)					
b. Voids/staledates under $10 (shall include listing of each transaction) (Reference Section G of Contract)					
c. Court Ordered Restitution (shall include listing of each transaction) (optional) (Reference Section G of Contract)					
4. TMA Approved Manual Transactions (Reference Section G of Contract)					
5. Final Check(s) to TMA (include payments from bank directly to TMA)					
B. Other Transactions:					
1. (list types of transactions) (e.g. installment payments, bank errors, transactions in transit, etc.)					
		TOTAL SECTION II			
III. END OF MONTH OUTSTANDING CHECK TOTAL:					
Month End Outstanding Check Total (YTD and Current Month will be same amount)		TOTAL SECTION III			
IV. ENDING BALANCE IN BANK ACCOUNT					
Month End Balance in Bank Account (YTD and Current Month will be same amount)		TOTAL SECTION IV *= Section I - (+Section II - Section III)*			

NON-FINANCIALLY UNDERWRITTEN BANK ACCOUNT RECONCILIATION REPORT
INSTRUCTIONS

GENERAL: This report shall follow and detail the cash flow through the bank accounts and justify the use of the money drawn by the contractor's bank, in the contractor's name, from the Federal Reserve (as well as any other deposits made to the non-financially underwritten bank accounts). This report should also identify any corrective action needed. This report will be balanced against TMA's records for transactions that have been approved by TMA. Any unreasonable, unjustified or unapproved transactions will be collected back from the contractor with applicable interest and penalty. Any transactions not specified in the format, shall be identified under "Other Transactions" as shown on the format and sufficiently explained. Questions concerning placement of items in the format shall be directed to TMA, CRM, Finance and Accounting. The report shall include the listings and explanations required below and have a report from the contractor's bank showing the beginning and ending balances for the month and the total debits, credits and adjustments for the entire month.

HEADING TO REPORT:

ACTIVITY FOR THE MONTH OF: All transactions shall be as of the end of the month being reported.
CONTRACTOR NAME: Name of the Prime Contractor
SUBCONTRACTOR NAME: Name of the Subcontractor
FISCAL YEAR: The Federal fiscal year for the transactions in the account. New accounts are started each October 1st for the new fiscal year.
ASAP ID NUMBER: The ASAP number used for transactions between the bank and the Federal Reserve Bank (provided by TMA, CRM for each bank account.)

REPORT FORMAT:

COLUMNS:

PREVIOUS MONTH'S YEAR TO DATE TOTAL: Shall equal the last column on the previous month's report.
THIS MONTH'S TRANSACTIONS: Shall be totals of the reporting month's transactions, categorized as shown on the report format. Outstanding Payments and Ending Balance are YTD figures so will be the same as YTD Total column.
REPORTING MONTH'S YEAR TO DATE TOTAL: The totals of the previous month's year to date totals plus the reporting month's totals.

TYPES OF TRANSACTIONS:

I. TRANSACTIONS DONE THRU THE FEDERAL RESERVE BANK - RICHMOND:
This is a total of all transactions done between the bank and the Federal Reserve-Richmond (the FED). These transactions will primarily be draws on the FED, which become deposits to the contractor's bank account. There may be some instances of the bank repaying the Fed for an overdrawn amount. These amounts should be netted against the amounts drawn for the total shown in this section.

II. TRANSACTIONS DONE IN CONTRACTOR'S BANK ACCOUNT:

A. Routine Bank Account Transactions (payments and other transactions authorized in the TRICARE Operations, Policy, or Reimbursement Manuals or Section G of the contract.

1. TEDs Automated Submission of Vouchers - TEDs provide the detailed information that supports the issuance of the payments on these bank accounts. These vouchers also include credits such as staledated check and voids that have been processed through the claims processing systems creating credit TEDs. (Note: Credits must relate to the account they are being processed against, i.e., they are a staledate or void, of check cut on that account or a refund that was deposited into that account.) For this report, only a total of the TEDs vouchers is needed. This total does not need to be broken down by programs.

2. Non-TEDs Vouchers – Capital Equipment/Direct Medical Education, Demonstrations, etc. - These vouchers do not have related TEDs but are supported by automated reports. These shall be broken down by type of program (i.e., CAP/DME, etc.). This is not applicable to the Pharmacy contract(s).

3. Credits not submitted on TEDS:

1. Voids/Staledates under $10 - Total of checks or payments under $10 that were voided or staledated during the reporting month including $.99 payment transactions that were not released. Reported amount must be supported by a listing of the reporting month's transactions. Do not include on this line if these were reported as TEDs.

2. Court Ordered Restitution - Use of this field is optional. This field may be used or the Court Ordered Restitution transactions may be included with other collections transactions. Reported amount must be supported by a listing of the reporting month's transactions. Do not include on this line if these were reported as TEDs.

4. TMA Approved Manual Transactions – Include transactions that have been submitted and approved by TMA, CRM for payment or collections that can not be handled by TEDs or Non-TED vouchers or Credits listed in #3 above. These should be rare. They must be approved by TMA, CRM prior to any payments being made. Payments will be thoroughly described and supported with adequate documentation and explanations as to why these transactions are not being done as a TED or routine Non-TED voucher (#1 or #2 above). Credits may be listed without approval but must be listed individually with explanations as to why they were not processed as a TED or Non-TED Voucher (#1 or #2 above).

5. Final Payment(s) to TMA – include payments made to TMA at the end of the bank accounts including payments made by the contractor and the bank.

B. Other Transactions:

This category is for transactions that may occur from time to time in a bank account such as bank errors that have not yet been corrected. These items must be cleared by the time the account is closed or be approved by TMA (#4 above). Identify type of transaction and amount affecting the bank balance. This also includes installment loan collections being held in the account during the year which is transferred to the next year's account at the end of the year.

III. End of the Month Outstanding Checks Total: This is the amount of checks that have not cleared the bank by the cut off for reconciliation, normally the end of the month.

III. ENDING BALANCE: This is the ending balance on the bank statement for the end of the last day of the period being reported, which is normally the end of the month. This should equal Section I - (+Section II - Section III).

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M260 Non-Financially Underwritten Bank Cleared Payment Report	3. SUBTITLE
4. AUTHORITY (Data Acquisition Document No.) N/A	5. CONTRACT REFERENCE RFP Section G	6. REQUIRING OFFICE TMA-CRM

17. PRICE GROUP: NSP

18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY MTHLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - By the 30th calendar day of the month following the first month of claims processing.

Block 13 - By the 30th calendar day of the month following the end of the month being reported.

The contractor shall require their bank to provide via an electronic transmission a list of all payments clearing the account and a listing of all deposits (may be daily totals for deposits). May be in the bank's format as long as bank's format includes detailed transaction data to include individual transaction identification (either EFT transaction codes or check numbers) , payee and dollar amount of payment. This will be submitted electronically.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: M270 Financially Underwritten Bank Cleared Payment Report
3. SUBTITLE:
17. PRICE GROUP: NSP

4. AUTHORITY *(Data Acquisition Document No.)*: N/A
5. CONTRACT REFERENCE: RFP Section G
6. REQUIRING OFFICE: TMA-CRM
18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ: NO
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: MTHLY
12. DATE OF FIRST SUBMISSION: See Block 16
8. APP CODE: N/A
11. AS OF DATE: O
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

16. REMARKS

Block 12 - By the 30th calendar day of the month following the first month of claims processing.

Block 13 - By the 30th calendar day of the month following the end of the month being reported.

The contractor shall require their bank to provide via an electronic transmission a list of all payments clearing the account and a listing of all deposits (may be daily totals for deposits). May be in the bank's format as long as bank's format includes detailed transaction data to include individual transaction identification (either EFT transaction codes or check numbers), payee and dollar amount of payment.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

G. PREPARED BY: Carol L. McCourt
H. DATE:
I. APPROVED BY: Laura L. Sells
J. DATE:

CONTRACT DATA REQUIREMENTS LIST

(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR
1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M280 Non-Financially Underwritten Bank Account Statement Report	3. SUBTITLE
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE RFP Section G	6. REQUIRING OFFICE TMA-CRM

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY MTHLY	12. DATE OF FIRST SUBMISSION See Block 16	17. PRICE GROUP NSP
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16	18. ESTIMATED TOTAL PRICE 0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - By the 30th calendar day of the month following the first month of claims processing.

Block 13 - By the 30th calendar day of the month following the end of the month being reported.

The contractor shall provide a report/statement created by their bank each month that includes the following information:

- Beginning Balance in the account(s)
- Total payments
- Total deposits
- Total adjustments (if applicable)
- Ending Balance in the account(s)

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ________

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M290 Monthly Autism Services Demonstration Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM, Chapter 18, Section 9	TMA	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	Monthly	Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	Block 16

16. REMARKS

The report shall be provided in Microsoft Excel format by the 15th calendar day of the month following the reporting period.

Monthly reporting periods cover the first day of the month through the end of the month.

Reports of EIA services are based on the date of service.

The monthly report shall include:

The number and percent of total participating beneficiaries by sex, age group (18 months-3 years, 4-6 years, 7-10 years, greater than 10 years), and sponsor's branch of Service.

The number of beneficiaries qualifying for the demonstration, by State, who were not receiving EIA services as of the end of that month due to lack of EIA Supervisors or EIA Tutors.

The total number of hours of EIA services provided per beneficiary.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning," "Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	M300 TQMC Monthly Validation Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 7 Sect 4 para 2.0	TMA-OCMO/TRO-CLIN OPS	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	MTHLY	Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	Block 16

16. REMARKS

Block 12 - No later than 45 calendar days from the date of receipt of request for records
Block 13 - No later than 45 calendar days from the date of receipt of request for records

The contractor shall account for 100% of the requested records with the selected records, accounting for all requested individual records, including follow-up actions and interventions for those records not transmitted.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST

(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning,""Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM M301 Present on Admission (POA) Indicators and Hospital Acquired Conditions (HACs) Monthly Report	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE TRM, Chapter 6, Section 8	6. REQUIRING OFFICE TMA MB&RB	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY	12. DATE OF FIRST SUBMISSION Block 16	14. DISTRIBUTION
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION Block 16	

16. REMARKS

Monthly reports are due by the 10th of each month following the reporting period and shall be provided in a Microsoft Excel format.

The monthly report shall be a listing of all TRICARE Encounter Data (TED) records that had HACs and will include, at a minimum:

TED Record Indicator
Each HAC reported
POA Indicator for each HAC
Dates of Service/Admission
DRG that was paid
Total amount paid by TRICARE
Provider Taxpayer Identification Number (TIN)
Provider Sub-Identifier (SUBID)
Provider Zip Code
Provider Type of Institution
National Provider Identified (NPI)

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet.			
15. TOTAL →	0	0	0

G. PREPARED BY Carol L. McCourt	H. DATE	I. APPROVED BY Laura L. Sells	J. DATE

DD FORM 1423-1, FEB 2001 PREVIOUS EDITION MAY BE USED.

Adobe Professional 7.0

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning," "Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

Quarterly Reports

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q010 Claims Audit Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1Sect 4 para 4.3	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	SEE BLOCK 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	SEE BLOCK 16

16. REMARKS

Block 12 - 45 days after the close of the 1st quarter that began after the start of health care delivery.
Block 13 - 45 days after the close of each quarter.

The contractor shall provide the results of the quarterly claims audit.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q020 Retrospective Review for Other Than DRG Validation Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 7 Sect 1 para 8.0	TMA/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - No later than 45 calendar days following the close of the first calendar quarter in which health care delivery occurs.

Block 13 - No later than 45 calendar days following the close of each calendar quarter.

The contractor shall provide a report of the quarterly focused review required to include a summary of findings and appropriate corrective actions.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q030 Beneficiary Access Assistance Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 11 Sect 3 paras 2.2, 2.2.2.	TMA/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 10 calendar days following the end of the first contract quarter.

Block 13 - No later than 10 calendar days following the end of each contract quarter.

The contractor shall submit a report of activities taken on behalf of beneficiaries requesting assistance in locating providers and obtaining access to care, with an additional summary report by state. These summary reports shall distinguish between enrolled and nonenrolled populations. The report shall include the number of referrals for Prime, Extra and Standard beneficiaries and for any non-TRICARE eligible beneficiaries; the source and reason for referral; the provider type to whom the beneficiary was referred; and the number of authorizations by medical/surgery and mental health services and by both inpatient and outpatient.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ______ TM ______ OTHER ______

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: Q040 Congressional and HBA Relations Report
3. SUBTITLE:
4. AUTHORITY (Data Acquisition Document No.): N/A
5. CONTRACT REFERENCE: TOM Chap 11 Sect 4 para 3.0
6. REQUIRING OFFICE: TMA/TRO-Prog Ops
7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: QTRLY
11. AS OF DATE: O
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16
17. PRICE GROUP: NSP
18. ESTIMATED TOTAL PRICE: 0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - 30 calendar days after the close of the first contract quarter
Block 13 - 30 calendar days after the close of each contract quarter thereafter

The contractor shall submit a summary report reflecting the actual number and the types of contacts (Congressional, BCAC, DCAO, HBA, etc.) completed. Documentation such as actual visit reports, contact reports, and internal contractor management monitoring reports are required for individual visits, but shall not routinely be sent to TMA. A special report shall be sent to the TMA whenever there is any special accomplishment achieved, special problems are encountered or when the contractor's representative receives a recommendation or request from a provider which needs special attention at TMA.

G. PREPARED BY: Carol L. McCourt
H. DATE:
I. APPROVED BY: Laura L. Sells
J. DATE:

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: Q050 Procedure Code Unbundling Report
3. SUBTITLE:
17. PRICE GROUP: NSP

4. AUTHORITY (Data Acquisition Document No.): N/A
5. CONTRACT REFERENCE: TOM Chap 13 Sect 3 para 3.7
6. REQUIRING OFFICE: TMA-PI/TRO
18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: QTRLY
11. AS OF DATE: O
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than 45 calendar days following the end of the first full calendar year of health care delivery
Block 13 - No later than 45 calendar days following the end of each calendar quarter

The contractor shall select the 10 most egregious providers (i.e., those providers, clinics, who most often unbundle and whose unbundling would have the highest dollar impact) for referral to the TMA PI based on the following criteria. Negative findings shall be reported with an explanation as to why no providers were identified. If the provider is already listed in previous reports, provide TMA PI with a newly identified provider who meets the criteria.

Criteria For Referral To TMA PI:

There is currently no open case on the provider in the contractor's Program Integrity Unit for other types of fraud or abuse.
Claims were submitted primarily on a participating provider basis.
The provider received payments in the amount of $25,000 or more during the most recent 12 month period.
The contractor's Program Integrity Unit received no requests from the TMA PI for data on the provider to be sent to the DCIS.
The contractor's program integrity staff has taken no action against the provider (e.g., no prepayment reviews initiated, no recoupment actions taken, etc.) other than to educate the provider regarding unbundling.

The contractor shall include the following information when referring a provider to the TMA PI:

Provider name and specialty.
All Employer Identification Numbers (EINs)/Taxpayer Identification Numbers (TINs), including sub-identifier, for this provider, to include care provided under other contracts, if applicable.
Provider's office addresses and billing addresses, if different.
Copies of letters, sample EOB, telephone or personal visit contact records supporting educational efforts in advising providers that unbundled billings are in violation of acceptable billing practices in accordance with 32 CFR 199.9.

(CONTINUED ON PAGE 2)

G. PREPARED BY: Carol L. McCourt
H. DATE:
I. APPROVED BY: Laura L. Sells
J. DATE:

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

Billing history to include the procedure codes that failed the rebundling edits, number of times they failed, dates of service range, total billed amount, total allowable amount for the unbundled procedures billed, rebundled procedure codes and total amount allowed and paid as a result of rebundling.

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO. HT9402-12-C-0001	F. CONTRACTOR

1. DATA ITEM NO. N/A	2. TITLE OF DATA ITEM Q060 Prepayment-Pre-encounter Screens Report	3. SUBTITLE	17. PRICE GROUP NSP
4. AUTHORITY *(Data Acquisition Document No.)* N/A	5. CONTRACT REFERENCE TOM Chap 13 Sect 4 para 1.0	6. REQUIRING OFFICE TMA-PI/TRO	18. ESTIMATED TOTAL PRICE 0.00

7. DD 250 REQ NO	9. DIST STATEMENT REQUIRED B	10. FREQUENCY QTRLY	12. DATE OF FIRST SUBMISSION See Block 16
8. APP CODE N/A		11. AS OF DATE O	13. DATE OF SUBSEQUENT SUBMISSION See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than 45 calendar days following the end of the first quarter of health care delivery.

Block 13 - No later than 45 calendar days following the end of the each quarter

The contractor shall report the findings and proposed remedial action from the quarterly prepayment/pre-encounter screen evaluation.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q070 Fraud and Abuse Summary Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	See Block 16	TMA-PI/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

16. REMARKS

Block 5 - TOM Chapter 13, Section 5, paragraph 1.0
Block 12 - Within 30 calendar days following the last day of the first calendar quarter within which health care was delivered under the contract.
Block 13 - Within 30 calendar days following the last day of each quarter.

The information from case reports will be compiled and submitted to TMA. Attach a listing of patient name and last four digits of sponsor's Social Security Number (SSN), provider name and provider number(s), or pharmacy name and pharmacy National Council of Prescription Drug Program (NCPDP) number(s), whichever is appropriate, to identify the referenced cases in the report that are found to be potential fraud/abuse cases. Also, include the potential fraud/abuse issue associated with each case.

The requirements are subject to change depending on the nature of new fraud schemes, contract changes, and/or regulatory/program provision changes.

Included in the Fraud and Abuse Summary Report (as an attachment) shall be:

A listing of all active investigations, by provider/beneficiary name and Taxpayer Identification Number (TIN)/last four of sponsor's SSN, being developed during the quarter, the date initiated, potential fraud/abuse issue (see TMA Form 435), and projected referral date to TMA PI. If not referred, disposition reason shall be included.

A listing of beneficiary/provers on prepayment review, by provider/beneficiary name and identifying information, such as TIN, last four of sponsor's SSN, basis for prepayment review, number of services suspended, denied, and dollar amounts. Problem Provider Case Listing and Unbundling report data.

See attached for report format.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

Quarterly Fraud/abuse Report

REPORTING PERIOD ENDED ________________,

The TRICARE Fraud and Abuse Case Report, TMA Form 435, will be completed on every case opened for initial investigation of potential fraud or abuse. The following information, which is essentially the same as on Form 435, will be submitted to the Program Integrity Office (PI), TRICARE Management Activity (TMA), within 30 days of the last day of each calendar quarter.

A. Case Workload Report

Number of cases over 25,000 (10,000 for pharmacy & dual-eligible) opened during quarter

Number of cases under 25,000 (10,000 for pharmacy & dual-eligible) opened during quarter

Number of cases referred to the TMA PI during quarter

Number of cases closed during quarter

Number of cases over 25,000 (10,000 for pharmacy & dual-eligible) opened during calendar year to date

Number of cases under 25,000 (10,000 for pharmacy & dual-eligible) opened during calendar year to date

Number of cases referred to the TMA PI during calendar year to date

Number of cases closed during calendar year to date

Number of cases over 25,000 (10,000 for pharmacy & dual-eligible) pending during quarter

Number of cases under 25,000 (10,000 for pharmacy & dual-eligible) pending during quarter

Total number of beneficiaries on prepayment review

Total number of providers on prepayment review

Attach a separate listing of cases opened/pended/closed during each quarter

B. Categorical Information on Cases Opened During this Quarter

Classification Of Subject	Number Of Cases
Beneficiary	
Physician	
General Practice	
Surgeon	
Psychiatrist	
Obstetrician	
Internal Medicine	
Anesthesiologist	

Quarterly Fraud/abuse Report (Continued)

Psychologist

B. Categorical Information on Cases Opened During this Quarter (Continued)	
Classification Of Subject	**Number Of Cases**
Podiatrist	
Other (Specify)	
Hospital	
Acute General	
Psychiatric	
Other (Specify)	
Skilled Nursing Facility	
Residential Treatment Center	
Specialized Treatment Facility	
Clinic, Group Practice	
Laboratory	
Medical Supplier	
Ambulance Service	
Registered Nurse	
Clinical Social Worker	
Marriage, Family and Pastoral Counselor	
Mental Health Counselor	
Occupational Therapist	
Pharmacy/Pharmacist	
Physical Therapist	
Others	
Total	

POTENTIAL FRAUD OR ABUSE ISSUES–REPORT AS FOLLOWS		
POTENTIAL ABUSE	**NUMBER OF CASES OPENED**	**TOTAL DOLLAR AMOUNT BY ISSUE**
Services Not Medically Necessary		$
Overutilization		$
Failure to File Claims (Provider)		$
Billing Administrative Charge for Filing Claims		$
Quality of Care		$
Other (Specify)		$

Quarterly Fraud/abuse Report (Continued)

FRAUD – REPORT AS FOLLOWS	NUMBER OF CASES OPENED	TOTAL DOLLAR AMOUNT BY ISSUE
Billing for Services Not Rendered		$
Misrepresenting Services/Diagnosis		$
Altering Bill/Receipt		$
Falsifying Records/Documents		$
Kickbacks/Rebates		$
Eligibility		$
Embezzlement		$
Forgery of Check		$
Other Health Insurance		$
Misrepresentation of Credentials		$
Breach of Provider Participation Agreement		$
Balance Billing Limitation		$
Misrepresenting Patient		$
Misrepresenting Provider		$
Other (Specify)		$
Total		$

FRAUD OR ABUSE REFERRAL SOURCE – REPORT AS FOLLOWS	NUMBER OF CASES OPENED
Beneficiary/Sponsor	
Clerical Identification	
Prepayment Review	
Postpayment Review	
Health Benefits Advisor	
Provider of Care	
Medical Review (Third Level)	
Media	
DEERS	
TMA	
DCIS	
Other Investigative Agency (Specify)	
Other Contractor	
OHI	
Public/anonymous	
Hotline Complaint	
Other (Specify)	

Quarterly Fraud/abuse Report (Continued)

DISPOSITION OF FRAUD AND ABUSE CASES -- REPORT AS FOLLOWS	NUMBER OF CASES
Place on Prepayment Review	
Provider Consultation	
Referred for Medical Review	
Referred to the TMA Program Integrity Office	
Case dismissed (no issue)	
Referred to Licensing Board	
Denied Payment	
Recouped Funds	
Referred to Contractor Recoupment Section	
Referred to the TMA Recoupment Section	
Provider Sanctioned (terminated or excluded)	
Other (specify)	

SAVINGS	RECEIVED THIS QUARTER	RECEIVED CY TO DATE
Provider Prepay/Review	$	$
Beneficiary Prepay Review	$	$
Provider Recoupment	$	$
Beneficiary Recoupment	$	$
Offsets	$	$
Denials (Specify)	$	$
Other (Specify) For example: "claimcheck," OHI, Drug Seeking Beneficiary controls, etc.	$	$
Total	$	$

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q080 Utilization Management Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 13 Sect 5 para 3.0	TMA-PI/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 45 calendar days following the end of the first calendar quarter of health care delivery.

Block 13 - No later than 45 calendar days following the end of each calendar quarter.

The contractor shall submit a Utilization Management Report on the review activities for TRICARE Prime, TRICARE Extra, and TRICARE Standard to prevent under-utilization or over-utilization of services.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	
B. EXHIBIT	
C. CATEGORY: TDP ___ TM ___ OTHER ___	
D. SYSTEM/ITEM	
E. CONTRACT/PR NO.	HT9402-12-C-0001
F. CONTRACTOR	
1. DATA ITEM NO.	N/A
2. TITLE OF DATA ITEM	Q090 Management of Myelomeningocele Study (MOMS) Report
3. SUBTITLE	
4. AUTHORITY (Data Acquisition Document No.)	N/A
5. CONTRACT REFERENCE	TOM Chap 18 Sect 3 para 9.2.5
6. REQUIRING OFFICE	TMA-MB&RS/TRO
7. DD 250 REQ	NO
8. APP CODE	N/A
9. DIST STATEMENT REQUIRED	B
10. FREQUENCY	QTRLY
11. AS OF DATE	O
12. DATE OF FIRST SUBMISSION	See Block 16
13. DATE OF SUBSEQUENT SUBMISSION	See Block 16
17. PRICE GROUP	NSP
18. ESTIMATED TOTAL PRICE	0.00

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 30 calendar days from the end of the first quarter beginning after the start of health care delivery
Block 13 - No later than 30 calendar days from the end of each quarter

The contractor shall establish and maintain a database of patients participating in the Management of Myelomeningocele Study (MOMS) Demonstration. The database shall include the patient's name, last four digits of sponsor's Social Security Number (SSN), name and number of protocol, treatment, hospital name and address and total cost. The database shall also include the date the TRICARE beneficiary was either accepted, or denied enrollment into the clinical trial and the patient shall be carried in the database until the Demonstration ends.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	
B. EXHIBIT	
C. CATEGORY: TDP ____ TM ____ OTHER ____	
D. SYSTEM/ITEM	
E. CONTRACT/PR NO.	HT9402-12-C-0001
F. CONTRACTOR	
1. DATA ITEM NO.	N/A
2. TITLE OF DATA ITEM	Q100 Evolving Practices Report
3. SUBTITLE	
17. PRICE GROUP	NSP
4. AUTHORITY (Data Acquisition Document No.)	N/A
5. CONTRACT REFERENCE	Policy Manual (TPM), Chap 1 Sect 2.1
6. REQUIRING OFFICE	TMA-OCMO/MB&RS/TRO/Prog Ops
18. ESTIMATED TOTAL PRICE	0.00
7. DD 250 REQ	NO
8. APP CODE	N/A
9. DIST STATEMENT REQUIRED	B
10. FREQUENCY	QTRLY
11. AS OF DATE	N/A
12. DATE OF FIRST SUBMISSION	See Block 16
13. DATE OF SUBSEQUENT SUBMISSION	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than 15 calendar days following the end of the first calendar quarter in which health care delivery occurs.

Block 13 - No later than 15 calendar days following the end of each calendar quarter.

The contractor shall keep abreast of new and evolving technologies and bring to TMA's attention via submission of a quarterly report, any device, medical treatment, or procedure they believe has moved from unproven to proven.

For each device, medical treatment, or procedure reported as having moved from unproven to proven, the contractor must submit actual copies of the articles, studies, technology assessment(s), etc., which substantiates their reported conclusion. A citation or reference page is not sufficient, and only reliable evidence as defined in 32 CFR 199.2 is acceptable.

TMA will review the supporting documentation provided, apply the standards and procedures in TRICARE regulation and policy, and make the final determination concerning the proven status of the devices, medical treatments, and/or procedures included in each quarterly report submitted by the contractor.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q110 Network Directory Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chapter 5 Section I para 2.4.1	TMA/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		See Block 16	See Block 16

16. REMARKS

Block 12 -No later than the 10th calendar day prior start of health care delivery
Block 13 - By the 10th calendar day prior to the start of each calendar quarter

The contractor shall list all network providers, their addresses and phone numbers, their specialties or types of service (Durable Medical Equipment (DME), supplies, etc.), and their contractually agreed allowable amount (discounts or price list). Such lists shall be provided in an electronic or paper format acceptable to the RD.

Format for report attached.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet and electronically to the MTF Commander			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

SubRegion	DMIS	PSA	Provider Name	TAX ID	Address	City, ST Zip	Phone	Specialty	Billed	CMAC	DRG	F/S	F/S .	Other	Other Descr
XX	XXXX	XXXXXX			XXX	XX	XX	XX	XX%	XX%					XX

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q120 Appeals Quality Assessment Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1 Sect 4 para 4.0 et seq.	TMA/TRO/Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 45 calendar days following the end of each contract quarter.

Block 13 - No later than 45 calendar days following the end of each contract quarter.

The contractor shall submit a quarterly report summarizing the results of their quality control program review on all appeals in the following format. The contractor shall also provide a narrative analysis of the errors/problems detected which includes the accuracy and completeness of the appeal processing, clarity of the documentation, and timeliness with reference to the quantitative standards for processing. All findings shall be documented, and the contractor shall describe how the findings will be used in a documented training program.

A. Expedited Medical Necessity Reconsiderations/Appeals
1. Time Frame audited:
2. Population (define):
3. Sample size:
4. Sample size percentage:
5. Number of Errors:
6. Error rate: XXX %
   numerator - number of errors
   denominator - sample size
7. Number of errors for:
   A. Accuracy:
   B. Completeness:
   C. Clarity:
   D. Timeliness:
   E. Misc./Other:

B. Non-expedited Medical Necessity Reconsiderations/Appeals
1. Time Frame audited:
2. Population (define):
3. Sample size:
4. Sample size percentage:
5. Number of Errors:
6. Error rate: XXX %
   numerator - number of errors
   denominator - sample size

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

7. Number of errors for :
   A. Accuracy:
   B. Completeness:
   C. Clarity:
   D. Timeliness:
   E. Misc./Other:

C. Non-expedited Factual Reconsiderations/Appeals
1. Time Frame audited:
2. Population (define):
3. Sample size:
4. Sample size percentage:
5. Number of Errors:
6. Error rate: XXX %
   numerator - number of errors
   denominator - sample size
7. Number of errors for :
   A. Accuracy:
   B. Completeness:
   C. Clarity:
   D. Timeliness:
   E. Misc./Other:

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	
B. EXHIBIT	
C. CATEGORY: TDP ___ TM ___ OTHER ___	
D. SYSTEM/ITEM	
E. CONTRACT/PR NO.	HT9402-12-C-0001
F. CONTRACTOR	
1. DATA ITEM NO.	N/A
2. TITLE OF DATA ITEM	Q130 Grievances Quality Assessment Report
3. SUBTITLE	
17. PRICE GROUP	NSP
18. ESTIMATED TOTAL PRICE	0.00
4. AUTHORITY *(Data Acquisition Document No.)*	N/A
5. CONTRACT REFERENCE	TOM Chap 1 Sect 4 para 4.0 et seq.
6. REQUIRING OFFICE	TMA/TRO/Prog Ops
7. DD 250 REQ	NO
8. APP CODE	N/A
9. DIST STATEMENT REQUIRED	B
10. FREQUENCY	QTRLY
11. AS OF DATE	O
12. DATE OF FIRST SUBMISSION	See Block 16
13. DATE OF SUBSEQUENT SUBMISSION	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later than 45 calendar days following the end of each contract quarter.

Block 13 - No later than 45 calendar days following the end of each contract quarter.

The contractor shall submit a quarterly report summarizing the results of their quality control program review on all grievances in the following format. The contractor shall also provide a narrative analysis of the errors/problems detected which includes the accuracy and completeness of the responses, clarity of the responses, and timeliness with reference to the quantitative standards for processing. All findings shall be documented, and the contractor shall describe how the findings will be used in a documented training program.

1. Time Frame audited:
2. Population (define):
3. Sample size:
4. Sample size percentage:
5. Number of Errors:
6. Error rate: XXX %
   numerator - number of errors
   denominator - sample size
7. Number of errors for:
   A. Accuracy:
   B. Completeness:
   C. Clarity:
   D. Timeliness:
   E. Misc./Other:

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q140 Written Correspondence Quality Assessment Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1 Sect 4 para 4.0 et seq.	TMA/TRO/Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - No later than 45 calendar days following the end of each contract quarter.

Block 13 - No later than 45 calendar days following the end of each contract quarter.

The contractor shall submit a quarterly report summarizing the results of their quality control program review on all written correspondence in the following format. The contractor shall also provide a narrative analysis of the errors/problems detected which includes the accuracy and completeness of the responses, clarity of the responses, and timeliness with reference to the quantitative standards for processing. Any lack of courtesy or respect in the responses shall also be noted. All findings shall be documented, and the contractor shall describe how the findings will be used in a documented training program.

1. Time Frame audited:
2. Population (define):
3. Sample size:
4. Sample size percentage:
5. Number of Errors:
6. Error rate: XXX %
   numerator - number of errors
   denominator - sample size
7. Number of errors for:
   A. Accuracy:
   B. Completeness:
   C. Clarity:
   D. Timeliness:
   E. Misc./Other:

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.:
B. EXHIBIT:
C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM:
E. CONTRACT/PR NO.: HT9402-12-C-0001
F. CONTRACTOR:

1. DATA ITEM NO.: N/A
2. TITLE OF DATA ITEM: Q150 Telephonic Responses Quality Assessment Report
3. SUBTITLE:
17. PRICE GROUP: NSP

4. AUTHORITY (Data Acquisition Document No.): N/A
5. CONTRACT REFERENCE: TOM Chap 1 Sect 4 para 4.0 et seq.
6. REQUIRING OFFICE: TMA/TRO/Prog Ops
18. ESTIMATED TOTAL PRICE: 0.00

7. DD 250 REQ: NO
8. APP CODE: N/A
9. DIST STATEMENT REQUIRED: B
10. FREQUENCY: QTRLY
11. AS OF DATE: O
12. DATE OF FIRST SUBMISSION: See Block 16
13. DATE OF SUBSEQUENT SUBMISSION: See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 45 calendar days following the end of each contract quarter.

Block 13 - No later than 45 calendar days following the end of each contract quarter.

The contractor shall submit a quarterly report summarizing the results of their quality control program review on all responses to telephonic inquiries in the following format. The contractor shall also provide a narrative analysis of the errors/problems detected which includes the accuracy and completeness of the responses, clarity of the responses, and timeliness with reference to the quantitative standards for processing. Any lack of courtesy or respect in the responses shall also be noted. All findings shall be documented, and the contractor shall describe how the findings will be used in a documented training program.

1. Time Frame audited:
2. Population (calls answered):
3. Sample size (# of calls selected for audit):
4. Sample size percentage:
5. Number of Errors:
6. Error rate: XXX %
   numerator - number of errors
   denominator - sample size
7. Number of errors for:
   A. Accuracy:
   B. Completeness:
   C. Clarity:
   D. Timeliness:
   E. Misc./Other:

G. PREPARED BY: Carol L. McCourt
H. DATE:
I. APPROVED BY: Laura L. Sells
J. DATE:

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ___ TM ___ OTHER ___

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q160 Behavioral Health Provider Location and Appointment Assistance		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 11 Sect 11	TMA/TRO/Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	QTRLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

16. REMARKS

Block 12 - No later than 25 calendar days following the end of each contract quarter.

Block 13 - No later than 25 calendar days following the end of each contract quarter.

The contractor shall provide reports of:

- Total number of calls answered that were from beneficiaries eligible to use the assistance service.
- Total number of ADSMs who contacted the assistance number.
- Total number of enrolled ADFMs who contacted the assistance number.
- Total number of ADSMs and ADFMs who stated they had or were assessed to have an emergent behavioral health issue.

- Number and percent of beneficiaries who selected Alternative 1.
  - -- Percent selecting Alternative 1 who chose to be contacted in a follow-up call by the contractor.
  - -- Number and percent selecting Alternative 1 and choosing to be contacted in a follow-up call who stated they were unable to make an appointment that would occur within a time frame satisfactory to them.
  - -- Average number of days from the date an appointment was made until the date the appointment was scheduled to occur as stated by beneficiaries during follow-up calls to beneficiaries who had chosen Alternative 1 and who had secured an appointment.

- Number and percent of beneficiaries who selected Alternative 2.
  - -- Percent of beneficiaries selecting Alternative 2 who chose to be contacted in a follow-up call by the contractor.
  - -- Number and percent of beneficiaries selecting Alternative 2 and choosing to be contacted in a follow-up call who stated they were unable to make an appointment that would occur within a time frame satisfactory to them.
  - -- Average number of days from the date an appointment was made until the date the appointment was scheduled to occur as stated by beneficiaries during follow-up calls to beneficiaries who had chosen Alternative 2 and who had secured an appointment.

- Number of times the contractor directed ADSMs or ADFMs to non-network providers due to lack of available appointments with MTF or network providers.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	Q170 Quarterly Autism Services Demonstration Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM, Chapter 18, Section 9	TMA	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	Quarterly	Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		0	Block 16

16. REMARKS

The report shall be provided in Microsoft Excel format by the 15th calendar day of the month following the reporting period.

The quarterly reporting period will be based on the Government's fiscal year.

The quarterly report shall consist of:

The number of EIA Supervisors and EIA Tutors, by State.

The number of EIA Supervisors with 0-4, 5-9, 10-14, 15-19, and 20 or more EIA Tutors, by State.

The number of, and the reasons why, beneficiaries seeking participation in the Demonstration do not meet eligibility criteria, by State.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet.			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning,""Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

Semi Annual Reports

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	
B. EXHIBIT	
C. CATEGORY:	TDP ____ TM ____ OTHER ____
D. SYSTEM/ITEM	
E. CONTRACT/PR NO.	HT9402-12-C-0001
F. CONTRACTOR	
1. DATA ITEM NO.	N/A
2. TITLE OF DATA ITEM	S010 DoD Cancer Clinical Trial Report
3. SUBTITLE	
17. PRICE GROUP	NSP
18. ESTIMATED TOTAL PRICE	0.00
4. AUTHORITY (Data Acquisition Document No.)	N/A
5. CONTRACT REFERENCE	TOM Chapter 18 Section 2
6. REQUIRING OFFICE	TMA-MB&RS/TRO
7. DD 250 REQ	NO
8. APP CODE	N/A
9. DIST STATEMENT REQUIRED	B
10. FREQUENCY	SEMIA
11. AS OF DATE	O
12. DATE OF FIRST SUBMISSION	See Block 16
13. DATE OF SUBSEQUENT SUBMISSION	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - No later September 1 of the first year of health care delivery
Block 13 - No later than March 1 and September 1 of each year

The contractor shall electronically submit a Cancer Clinical Trial Report. The semiannual report shall outline the number of TRICARE patients enrolled in each protocol and the outcome. The report shall indicate the date the TRICARE beneficiary was accepted into the protocol and the patient shall be carried on the report until the demonstration ends. The report shall also include a list of patients who were denied enrollment and the reason for each denial.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	S020 Semiannual Autism Services Demonstration Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM, Chapter 18, Section 9	TMA	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	Semiannual	Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	Block 16

14. DISTRIBUTION			
a. ADDRESSEE	b. COPIES: Draft	Final: Reg	Final: Repro
Submit through the			
TMA E-commerce			
Extranet.			
15. TOTAL →	0	0	0

16. REMARKS

The report shall be provided in Microsoft Excel format by the 15th calendar day on the month following the reporting period.

Semi-annual reporting periods are based on the Government's fiscal year (October 1 through March 31 and April 1 through September 30).

Reports of EIA services are based on the date of service.

The semiannual report shall consist of:

The name and SSN of the sponsor of each beneficiary who received services under the Demonstration; including the total number of the sponsor's dependents who received or are receiving EIA Services under the Demonstration.

Number and percentage of compliance audits, as specified in the TOM, Chapter 18, Section 9, paragraph 11.5, that resulted in an outcome of "Fail."

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

16. REMARKS *(Continued)*

INSTRUCTIONS FOR COMPLETING DD FORM 1423

(See DoD 5010.12-M for detailed instructions.)

FOR GOVERNMENT PERSONNEL

Item A. Self-explanatory.

Item B. Self-explanatory.

Item C. Mark (X) appropriate category: TDP - Technical Data Package; TM - Technical Manual; Other - other category of data, such as "Provisioning," "Configuration Management," etc.

Item D. Enter name of system/item being acquired that data will support.

Item E. Self-explanatory (to be filled in after contract award).

Item F. Self-explanatory (to be filled in after contract award).

Item G. Signature of preparer of CDRL.

Item H. Date CDRL was prepared.

Item I. Signature of CDRL approval authority.

Item J. Date CDRL was approved.

Item 1. See DoD FAR Supplement Subpart 4.71 for proper numbering.

Item 2. Enter title as it appears on data acquisition document cited in Item 4.

Item 3. Enter subtitle of data item for further definition of data item (optional entry).

Item 4. Enter Data Item Description (DID) number, military specification number, or military standard number listed in DoD 5010.12-L (AMSDL), or one-time DID number, that defines data content and format requirements.

Item 5. Enter reference to tasking in contract that generates requirement for the data item (e.g., Statement of Work paragraph number).

Item 6. Enter technical office responsible for ensuring adequacy of the data item.

Item 7. Specify requirement for inspection/acceptance of the data item by the Government.

Item 8. Specify requirement for approval of a draft before preparation of the final data item.

Item 9. For technical data, specify requirement for contractor to mark the appropriate distribution statement on the data (ref. DoDD 5230.24).

Item 10. Specify number of times data items are to be delivered.

Item 11. Specify as-of date of data item, when applicable.

Item 12. Specify when first submittal is required.

Item 13. Specify when subsequent submittals are required, when applicable.

Item 14. Enter addressees and number of draft/final copies to be delivered to each addressee. Explain reproducible copies in Item 16.

Item 15. Enter total number of draft/final copies to be delivered.

Item 16. Use for additional/clarifying information for Items 1 through 15. Examples are: Tailoring of documents cited in Item 4; Clarification of submittal dates in Items 12 and 13; Explanation of reproducible copies in Item 14.; Desired medium for delivery of the data item.

FOR THE CONTRACTOR

Item 17. Specify appropriate price group from one of the following groups of effort in developing estimated prices for each data item listed on the DD Form 1423.

a. Group I. Definition - Data which is not otherwise essential to the contractor's performance of the primary contracted effort (production, development, testing, and administration) but which is required by DD Form 1423.

Estimated Price - Costs to be included under Group I are those applicable to preparing and assembling the data item in conformance with Government requirements, and the administration and other expenses related to reproducing and delivering such data items to the Government.

b. Group II. Definition - Data which is essential to the performance of the primary contracted effort but the contractor is required to perform additional work to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, or quality of the data item.

Estimated Price - Costs to be included under Group II are those incurred over and above the cost of the essential data item without conforming to Government requirements, and the administrative and other expenses related to reproducing and delivering such data item to the Government.

c. Group III. Definition - Data which the contractor must develop for his internal use in performance of the primary contracted effort and does not require any substantial change to conform to Government requirements with regard to depth of content, format, frequency of submittal, preparation, control, and quality of the data item.

Estimated Price - Costs to be included under Group III are the administrative and other expenses related to reproducing and delivering such data item to the Government.

d. Group IV. Definition - Data which is developed by the contractor as part of his normal operating procedures and his effort in supplying these data to the Government is minimal.

Estimated Price - Group IV items should normally be shown on the DD Form 1423 at no cost.

Item 18. For each data item, enter an amount equal to that portion of the total price which is estimated to be attributable to the production or development for the Government of that item of data. These estimated data prices shall be developed only from those costs which will be incurred as a direct result of the requirement to supply the data, over and above those costs which would otherwise be incurred in performance of the contract if no data were required. The estimated data prices shall not include any amount for rights in data. The Government's right to use the data shall be governed by the pertinent provisions of the contract.

Weekly Reports

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	W010 CLAIMS AGING REPORT BY STATUS/LOCATION		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1 Sect 4 para 3.1	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	WEKLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

16. REMARKS

Block 12 - 1st workday of the week following the start of health care delivery.
Block 13 - 1st workday of the week following the week reported.

The contractor shall furnish claims aging reports by Status Location on the first workday following the reporting week. Only one Status Location for each claim suspended is allowed. These reports shall be sorted to enable a count of the total number of claims pending for a specified length of time; e.g., over 30 days, over 60 days and over 120 days. The contractor shall include excluded and retained claims on each report. Unless specifically requested by TMA or unless the contractor customarily makes a run of these reports concurrent with preparation of the month-end reports to TMA, they need not balance with the end-of-month reports. The contractor shall prepare an explanation of the individual reports and interpretation of the locations specific to each report to enable TMA staff to effectively review the data.

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	W020 INCOMING CONTRACTOR WEEKLY STATUS REPORT		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1 Sect 7 para 2.11	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	WEKLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		O	See Block 16

16. REMARKS

Block 12 - 20th calendar day following "Notice of Award".
Block 13 - 1st day of the week following the week reported through the 180th day following the start of health care delivery.

The incoming contractor shall submit a weekly status report of phase-in and operational activities and inventories. The status report will address only those items identified as being key to the success of the transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL →	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	W030 Outgoing Contractor Weekly Status Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 1 Sect 7 para 4.3.6	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	WEKLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - 20th calendar day following the Specifications Meeting.
Block 13 - 1st workday of the week following the week reported until otherwise specified by the PCO to discontinue.

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities. This shall be done in accordance with specifications of the official transition schedule.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	W040 SCHP Aging Claims Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	TOM Chap 17 Sect 3 para 9.0	TMA-CO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	WEKLY	See Block 16
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION
N/A		0	See Block 16

16. REMARKS

Block 12 - First workday of the week following the start of health care delivery
Block 13 - First workday of the week following the week reported or as directed by the Contracting Officer.

No less frequently than once per week, the contractor shall provide a report listing those claims which have been pended awaiting SPOC action, and the age of those claims. The age breakouts reported in this report may be based upon the same categories as reported in the Monthly Cycle Time/Aging reports. In the alternative, they may be configured based upon existing workload management reports used internally by the contractor including a copy of the relevant portion of such an internal report.

14. DISTRIBUTION a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet and directly to the SPOC			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	W050 Weekly Claims Processing Statistics Report		NSP

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6., CP.1.	TMA-CO/TRO	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	WEKLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

16. REMARKS

Block 12 - 1st day of the week following the start of health care delivery.
Block 13 - 1200 MT 1st day of the week following the week reported.

Data to be reported include totals for:

Claims, to include opening, pending, new receipts, adjustments identified, transfers, claims processed, and adjustments processed; and closing pending claims and adjustments, sorted by aging category.

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the			
TMA E-commerce			
Extranet			
15. TOTAL	0	0	0

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	

CONTRACT DATA REQUIREMENTS LIST (1 Data Item)	Form Approved OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP ____ TM ____ OTHER ____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR
	HT9402-12-C-0001	

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
N/A	W060 Purchased Care Active Duty Inpatient Census Report		NSP

4. AUTHORITY (Data Acquisition Document No.)	5. CONTRACT REFERENCE	6. REQUIRING OFFICE	18. ESTIMATED TOTAL PRICE
N/A	RFP C.6.MM.4., MGT.13.	TMA-OCMO/TRO-Prog Ops	0.00

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
NO	B	WEKLY	See Block 16
8. APP CODE		**11. AS OF DATE**	**13. DATE OF SUBSEQUENT SUBMISSION**
N/A		O	See Block 16

14. DISTRIBUTION

a. ADDRESSEE	b. COPIES Draft	Final Reg	Final Repro
Submit through the TMA E-commerce Extranet and submit directly to the TRO and TMA OCMO			
15. TOTAL	0	0	0

16. REMARKS

Block 12: Data retrieved from contractor database as of 2400 hours every Monday beginning after start of services

Block 13: Before 1200 hours every Tuesday.

Managed Care Support Contractors will provide a weekly report of all active duty personnel who are inpatients in a network or non-network facility as of 2400 every Monday. The report data fields will be as furnished below and formatted in an Excel spreadsheet.

Required Data Items:

Region
Authorization Number
Enrollment DMIS ID
Enrollment DMIS Name
Ordering DMIS ID
Admission Date
Facility ID
Network or Non-Network
Facility Type
Facility Name
Facility State
EDIPN
Last Name
First Name
Branch of Service
Diagnosis 1 Code
Diagnosis 1 Description
Diagnosis 2 Code
Diagnosis 2 Description
Diagnosis 3 Code
Diagnosis 3 Description
Patient Enrolled in Contractor Case Management - Yes or No

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE
Carol L. McCourt		Laura L. Sells	